

LOGISTICS SUPPORT AND MOBILIZATION PLANNING INTERIM GUIDANCE



BUREAU OF MEDICINE AND
SURGERY



DEPARTMENT OF THE NAVY

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INTERIM GUIDANCE

Ref: (a) NAVMEDCOMINST S4812.1A of 28 May 85

Encl: (1) LSMP Interim Guidance

1. Enclosure (1) is issued as interim unclassified guidance to be followed until the next published revision of reference (a).
2. Enclosure (1) is to be used instead of reference (a) for planning guidance and does contain significant changes. You are encouraged to dialogue issues with the Bureau of Medicine and Surgery as you develop mobilization plans.
3. Points of contact regarding this matter are Commander J. E. Greenan, III, MSC, USN, and Commander Leon C. Harris, MSC, USNR, at AUTOVON 294-1060 or commercial (202) 653-1060.

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FORWARD

This document provides policy and guidance to Plans, Operations and Medical Intelligence Officers (POMIs), referred to as "planners" throughout this document, in developing Logistics Support and Mobilization Plans (LSMP) for medical and dental activities. In addition, it serves as a ready reference during the mobilization planning process.

The document is divided into nineteen chapters and contains a listing of appendices. Chapters 1 through 18 are the Bureau of Medicine and Surgery's policy and guidance for mobilization planning. Chapter 19 is a hypothetical mobilization scenario intended as a means to stimulate thinking on the mobilization process as it might occur at a medical or dental activity. The scenario escalates toward full mobilization. The appendices contain other reference material to assist the medical planner.

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CHAPTER 1

ACRONYMS AND ABBREVIATIONS

ABFC	Advanced Base Functional Component
AC	Active Component
ACLS	Advanced Cardiac Life Support
ADAL	Authorized Dental Allowance List
ADCON	Administrative Control
ALCON	All Concerned
AMAL	Authorized Medical Allowance List
AOA	Amphibious Objective Area
AOR	Area of Responsibility
APOD	Aerial Port of Debarkation
APOE	Aerial Port of Embarkation
ASMRO	Armed Services Medical Regulating Office
ASWBPL	Armed Services Whole Blood Processing Laboratories
ATF	Amphibious Task Force
AUTODIN	Automatic Digital Network
BAS	Battalion Aid Station
BDC	Blood Donor Center
BOS	Base Operating Support
BPD	Base Planning Document
BPO	Blood Program Office
BUMED	Bureau of Medicine and Surgery
CATF	Commander, Amphibious Task Force
C-DAY	The unnamed day upon which a deployment operation is to commence.
CBR	Chemical, Biological, Radiological
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CINC	Commander in Chief
CINCFOR	US Forces Command
CINCLANTFLT	Commander in Chief, US Atlantic Fleet
CINCPACFLT	Commander in Chief, US Pacific Fleet
CINCUSNAVEUR	Commander in Chief, US Naval Forces, Europe
CINCUSNAVCENT	Commander in Chief, US Naval Forces, Central Command
CLF	Commander, Landing Force
CMC	Commandant of the Marine Corps
CNO	Chief of Naval Operations
CONPLAN	Concept Plan
CONUS	Continental United States

CONUSA
COOPPLAN
CRTS
CTF

Continental US Army
Continuity of Operations Plan
Casualty Receiving and Treatment Ships
Commander, Task Force

D-Day

The unspecified day upon which hostilities commence

DEFCON

Defense Condition

DHHS

Department of Health and Human Services

DLA

Defense Logistics Agency

DNBI

Disease and Non-Battle Injury

DOD

Department of Defense

DON

Department of the Navy

DOR

Dental Operating Room

DOU

Dental Operating Unit

DPG

Defense Planning Guidance

DTF

Dental Treatment Facility

DTR

Dental Treatment Room

EAD

Earliest Arrival Date

EFAP

Emergency Fleet Augmentation Plan

EPMAC

Enlisted Personnel Management Center

EPMU

Environmental and Preventive Medicine Unit

ETA

Estimated Time of Arrival

ETD

Estimated Time of Departure

FAC(A)

Officer and enlisted billets designated as Functional Area Code (A) are unfilled during peacetime and require active duty fill upon mobilization

FAC(U)

Officer billets designated as Functional Area Code (U) are US Marine Corps billets filled by personnel assigned additional duty to Navy medical and dental treatment facilities.

FEBA

Forward Edge of the Battle Area

FEMA

Federal Emergency Management Agency

FIC

Fleet Intelligence Center

FLOT

Forward Line of Own Troops

FMF

Fleet Marine Force

FMSS

Field Medical Service Schools, Marine Corps Bases, Camp Pendleton, CA, and Camp Lejeune, NC

FRN

Force Requirement Number

FSSG

Force Service Support Group

FYDP

Five Year Defense Program

GME

Graduate Medical Education

HLTHCARE SUPPO
HSETC
HSO

Healthcare Support Office
Health Sciences Education and Training Command
Healthcare Support Office

IAW
ICMMP
ICU
IMA
IOC
IRR
ISIC

In accordance with
Integrated CONUS Medical Mobilization Plan
Intensive Care Unit
Individual Mobilization Augmentees
Initial Operating Capability
Individual Ready Reserve
Immediate Superior in Command

JCG
JCS
JDS
JMMO
JMRO
JOPES
JRDC
JSCP

Joint Control Group
Joint Chiefs of Staff
Joint Deployment System
Joint Medical Mobilization Office
Joint Medical Regulating Office
Joint Operation Planning System
Joint Regional Defense Command
Joint Strategic Capabilities Plan

LAD
LCAC
LDC
LERTCON
LF
LHA
LHD
LKA
LOC
LOI
LPD
LPH
LSD
LST

Latest Arrival Date
Landing Craft, Air Cushion
Land Defense of CONUS
Alert Condition
Landing Force
Landing Helicopter Assault Ship
Amphibious Assault Ship (Multi-purpose)
Landing Ship Cargo Attack
Line of Communication
Letter of Instruction
Landing Platform Dock
Landing Platform Helicopter
Landing Ship Dock
Landing Ship Tank

M-DAY

Unspecified day upon which mobilization commences

MEB
MAC
MEF
MAGTF
MANMED
MAP
MARG
MEU
MED/LANTOUTUS

Marine Expeditionary Brigade
Military Airlift Command
Marine Expeditionary Force
Marine Air Ground Task Force
Manual of the Medical Department
Medical Augmentation Plan
Marine Amphibious Readiness Group
Marine Expeditionary Unit
Mediterranean/Atlantic areas outside the Continental United States

MILCON	Military Construction Program
MMART	Mobile Medical Augmentation Readiness Team
MPA	Manpower Authorization
MPM	Medical Planning Module
MPUAS	Medical Personnel Unit Augmentation System
MSC	Military Sealift Command
MSCA	Military support to civil authorities
MSCD	Military support to civil defense
MTF	Medical Treatment Facility
MTMC	Military Traffic Management Command
MPAT	Military Patient Administration Team
NAMMOS	Navy Manpower Mobilization System
NATO	North Atlantic Treaty Organization
NAVDISVECTECOLCONCEN	Navy Disease Vector Ecology Control Centers
NAVENVIRHLTHCEN	Navy Environmental Health Center
NAVMEDLOGCOM	Naval Medical Logistics Command
NAVOPHTHALSUPTRACT	Naval Ophthalmic Support and Training Activity
NAVMILPERSCOM	Naval Military Personnel Command
NAVWARPS	Navy War Reserve Projects
NBC	Nuclear, Biological, Chemical
NCA	National Command Authority
NCMP	Navy Capabilities and Mobilization Plan
NDMS	National Disaster Medical System
NEC	Navy Enlisted Classification
NEO	Noncombatant Evacuation Operations
NIFFM	Nonindustrial Facilities for Mobilization
NMPC	Naval Military Personnel Command
NOBC	Naval Officer Billet Classification
NOFORN, NF	Not Releasable to Foreign Nationals
NRFI	Not Ready for Issue
NSA	National Security Agency
NWP	Naval Warfare Publication
OASD(HA)	Office of the Assistant Secretary of Defense, Health Affairs
OCONUS	Outside Continental US
OPCON	Operational Control
OPEC	Organization of Petroleum Exporting Countries
OPER	Operating
OPLAN	Operation Plan
OWRMR	Other War Reserve Materiel Requirement
PACOUTUS	Pacific area outside the Continental United States
PASEP	A message passed separately
PCMO	Primary Care Medical Officer
PCRTS	Primary Casualty Receiving and Treatment Ships

PCS	Permanent Change of Station
PIN	Passenger Increment Number
PIM	Pretrained Individual Manpower
POD	Port of Debarkation
POE	Port of Embarkation
POM	Program Objective Memorandum
POMI	Plans, Operations, and Medical Intelligence Officer
PPA	Principal Planning Agent
PPBS	Planning, Programming, and Budgeting System
PRC	Peoples Republic of China
PWRMR	Prepositioned War Reserve Materiel Requirement
PWRMS	Prepositioned War Reserve Materiel Stock
RADDR	Readdress
RC	Reserve Component
RD MF	Rapidly Deployable Medical Facility
RDT&E	Research, Development, Test, and Evaluation
RLC	Responsible Line Commander
RLT	Regimental Landing Team
ROK	Republic of Korea
RPA	Regional Planning Agent
SECDEF	Secretary of Defense
SELRES	Selected Reserve
SITREP	Situation Report
SOP	Standard Operating Procedures
SORTS	Status of Readiness and Training System
SPOD	Sea Port of Debarkation
SPOE	Sea Port of Embarkation
SPMS	Standard Personnel Management System
SYDP	Six Year Defense Plan
TAD	Temporary Additional Duty
TAR	Training Active Reserve
TOE	Table of Organization and Equipment
TPFDD	Time-phased Force Deployment Data
TPFDL	Time-phased Force Deployment List
TPTRL	Time-phased Transportation Requirement List
TPS&D	Personnel or billets that are unavailable due to travel, prisoner status, sickness, or temporary disability
TRANSCOM	US Transportation Command
T-AH	Hospital Ship
TUCHA	Type Unit Characteristics File
UIC	Unit Identification Code

WIA
WIN
WWMCCS

Wounded in Action
WWMCCS Intercomputer Network
Worldwide Military Command and Control System

CHAPTER 2

INTRODUCTION AND BACKGROUND

1. The current world situation and the relative balance of strategic might between the United States and the USSR has caused a considerable realignment in defense planning priorities. The ability of the United States to mobilize in an orderly, flexible, and timely manner is the key to deterrence and warfighting capabilities.
2. Webster's definition of "mobilize" is short and simple: "To assemble and make ready for war duty." The act of mobilization, however, is a highly complex process of indeterminate scope and duration. The United States has experienced mobilizations of varying degrees during many conflicts and wars. Modern technology and communication have changed many mobilization policies and procedures developed during the two World Wars and other lesser conflicts. Mobilization planning was afforded a relatively low priority after World War II during the period of U.S. strategic superiority when a prolonged conventional conflict was not considered likely.
3. The Department of Defense (DoD) groups mobilization into three general categories: partial mobilization, full mobilization and total mobilization.
4. Partial mobilization broadly defined as "less than full mobilization," is a flexible option that can be tailored to specific DoD requirements, and can range in scope from activating only selected reserve component (RC) units to a level just short of full mobilization. Because the level of mobilization is scenario dependent, planning must be flexible and, wherever possible, based on specific contingency and operation plans of the Commanders in Chief (CINCs).
5. The category best understood and most useful for detailed planning is full mobilization. This involves the time-phased mobilization of all RC units to expand the active duty structure of the Armed Forces to a level approved by Congress. Since the size of the total force is fixed, support requirements and shortfalls can be easily identified for planning. Partial and full mobilizations are neither clear-cut nor easy to plan.
6. Total mobilization describes the very highest level of national preparedness. It is defined as an "expansion of the existing

approved force structure" by the formation of additional military organizations and units by civilian sources. World War II was an example of total mobilization in which the Armed Forces were extensively expanded. Planning for total mobilization must also be flexible since, depending on world events, it could vary from a moderate expansion to a maximum national effort as in World War II.

7. Numerous federal, state, and local organizations are involved in mobilization planning to varying degrees. Within DoD, the process begins with developing operation plans in concept format (CONPLANS) or operation plans (OPLANS) by the CINCs of the U.S. unified commands. The plans are reviewed and approved by the Joint Chiefs of Staff (JCS) and are used by the military services to determine force structure needs and mobilization requirements. The active component (AC) units are generally scheduled for early deployment while reserve component (RC) units are being activated. The Federal Emergency Management Agency (FEMA) and approximately 35 federal civil departments and agencies plan extensively for mobilization of the civilian sector to support DoD. Industrial expansion, financial stabilization, and civil defense are examples of the many areas included in their plans. FEMA also coordinates state and regional emergency planning for mobilization.

8. The DoD Master Mobilization Plan summarizes the responsibilities and functions of DoD's principal components in mobilization planning and execution. It describes the emergency authorities available to the President, the Secretary of Defense, and other senior DoD executives in crises that require national mobilization. It also includes decision option papers for key mobilization actions.

9. DoD guidance and statements by Congress clearly enunciate that the military Medical Departments exist to support their combat forces on the battlefield and, in peacetime, to help them prepare for war. The Medical Department must be prepared for the entire spectrum of warfare from low intensity conflict to global, high-intensity war. Preparation for war includes: identification of the medical threat; development of medical organizations and systems to support potential battlefields; training medical units and personnel for their wartime roles; training nonmedical personnel in medical subjects; medical research to discover new techniques and materiel to preserve the fighting strength; and the provision of both preventive and restorative health care to the military force. The peacetime medical capability required for war, when not employed in the preparation for wartime medical support, will be used to provide healthcare to eligible beneficiaries.

10. The size of the total (AC and RC) military medical force is determined largely by the size of the military force it supports in war. Included are the medical forces deployed to the theater

of war, other overseas military medical requirements, the continental United States (CONUS) military medical training base, and the military medical force needed to provide preventive and restorative care in CONUS to the mobilizing population and to patients evacuated from outside CONUS (OCONUS). Only those patients who can be returned to duty within a predefined period of time will be held in CONUS military medical facilities. Others will receive care in Veterans Administration hospitals and civilian hospitals participating in the National Disaster Medical System (NDMS). Most of the required military medical force will consist of the RC. The size of the AC is based on the medical forces required until mobilization of the RC can be completed.

11. Today, Military Departments plan to operate their own healthcare delivery and training systems upon mobilization. The priority for all resources is the theater of operations. This will create critical shortages in some categories of manpower and supplies in CONUS. Management of shortages is accomplished by the individual services. Supplies are issued with existing JCS material allocation procedures. New manpower is allocated based upon the definition of the requirement of each service.

12. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) initiative calls for provision of health care in CONUS under a single set of policies and procedures resulting in the effective use of high demand healthcare resources during wartime. To implement this objective, the Joint Medical Mobilization Office (JMMO) was established for the integrated planning of all CONUS military medical treatment resources to ensure standard policies and procedures.

13. JMMO ensures developing an integrated plan for all CONUS military medical activities during wartime. The plan includes: expansion of the military medical training base; provision of preventive/restorative care to the mobilizing population; provision of medical care to military patients returning from OCONUS; and allocation of military health care facilities, manpower, and materiel not deployed to the theaters of operation. Theater of operation resource requirements will have first priority.

14. A major readiness goal established by the Department of the Navy (DON) has been ensuring that continuous planning is conducted by all military headquarters, including planning with the civilian sector. Associated with this planning effort are issues on developing a capabilities based planning system, command relationships, contingency planning, using of existing assets, creating resource requirements, and outlining essential training elements. Therefore, timely and intelligent decisions have to be made concerning the establishment of tasks and

allocation of resources. The extent to which these are reviewed and studied in peacetime will help ensure optimal decisions are reached during emergency and contingency situations.

15. BUMED provides the critical healthcare mission support for the mobilization, deployment, and sustainment of U.S. Naval forces in military operations. To define the process required to establish and maintain a CONUS base to sustain a military operation in a global war, a significant amount of government-wide attention has been focused on the National Security Emergency Preparedness Program as set forth in National Security Department Directive 188.

16. Mobilization and wartime sustainment operations cannot be viewed as simply a more hectic and demanding pace of peacetime operations. To healthcare providers, however, this may occur because they are fully occupied today in demanding clinical situations requiring quality care. In wartime operations, these providers will be fully occupied; however the critical step for planners will be to match individual talents, health facilities, supplies and equipment to a prioritized patient flow resulting in the highest quality of healthcare.

17. DON, Fleet CINCs, and BUMED have initiated mobilization readiness programs that are targeted at their particular needs and unique missions.

CHAPTER 3

PLANNING POLICY AND GUIDANCE

1. Introduction

a. This chapter contains BUMED policy and guidance for logistics support and mobilization planning. Policy and guidance on manpower, personnel, materiel, and maintenance are addressed in subsequent chapters.

b. The LSMP provides policy and guidance for execution of command responsibilities in support of authorized forces and for time-phased expansion of the command's role and resources during mobilization.

c. The LSMP supports the Navy Capabilities and Mobilization Plan (NCMP) and is in consonance with the Joint Strategic Capabilities Plan (JSCP).

2. References. The following references provide additional guidance and support the contents of this plan:

a. NAVMEDCOMINST C3500.1B, Uniform System of Alert Conditions (LERTCONS)

b. Naval Warfare Publication (NWP-6 Rev C)

c. NAVMEDCOMINST 6440.2

d. Naval Warfare Publication (NWP-10)

e. OPNAVINST 1000.16G

f. OPNAVINST 3440.16A

3. Background

a. The NCMP and LSMPs are part of a "family of plans" that originates with the President, extends through the Secretary of Defense (SECDEF), JCS, military departments, and various echelons of command within each service. These plans are essential for building, tailoring, and effectively employing our military forces. The NCMP contains a scenario for a prolonged, global, conventional war that provides the basis for Navy echelon II logistics support and mobilization planning. LSMPs are prepared

by selected Navy echelon II commands and their subordinate or supporting commands as directed, for their mobilization and for providing logistics support under a scenario directed by the operating forces.

b. BUMED directs the provision of medical and dental services for Navy and Marine Corps personnel and others in cooperation with responsible line commanders (RLC). BUMED plans for the continuity of operations (COOPLAN); maintains the capability to augment the operating forces with trained active duty personnel; and, in conjunction with the Commander, Naval Military Personnel Command; Commander, Naval Reserve Force; and the Commanding Officer, Naval Reserve Personnel Center, plans for the manning of additional deployable medical assets and the reestablishment and expansion of the CONUS naval healthcare system.

c. The LSMP provides the preparing command with a ready source of information for rapid and responsive contingency planning.

4. Scope

a. This plan is approved by Chief, BUMED for 2 years from the date of publication.

b. The BUMED LSMP is a planning document that, coupled with guidance in the NCMP, provides logistical guidance and direction for medical support of Navy and Marine Corps forces. It is intended to serve the following purposes:

(1) Provide guidance for medical logistics in support of Navy strategic and logistic policies under peacetime, contingency, and general war conditions;

(2) Identify BUMED's tasks and objectives, and specify plans for fulfilling them upon mobilization;

(3) Provide essential planning details to the Chief of Naval Operations (CNO) for medical support of the NCMP and for coordination of medical support for naval component commanders;

(4) Furnish planning guidance for activities under the command of the CINCs and Commander, Naval Education and Training (CNET) and primary support of BUMED; ensure medical assets under BUMED cognizance needed to support the NCMP are available and ready; and aid in the orderly transition from peacetime to mobilization and support of wartime operations;

(5) Provide time-phased support of OPLANS identified by CINC planners during contingency or general war conditions.

(6) Coordinate essential medical planning data with other supporting commands within the DoD.

5. Command and Control. BUMED is an echelon 2 command under the command and control of CNO. BUMED performs budget formulation and execution; provides manpower, facilities and materiel; establishes clinical standards; and assures total quality management.

a. Through assignment of Navy shore-based hospitals and clinics to the CINCs and CNET, they exercise control through the local Navy/Marine Corps base or station commander. Hospital or clinic commanders report directly to the base commander, who ultimately reports to the CINCs or CNET.

b. BUMED exercises command and control over seven mission-specific commands:

(a) Naval Health Sciences Education and Training Command (HSETC);

(b) Navy Environmental Health Center (NAENVIRHLTHCEN);

(c) Naval Medical Data Services Center (NAVMEDDATASERVCE);

(d) Naval Medical Logistics Command (NAVMEDLOGCOM);

(e) Naval Ophthalmic Support and Training Activity (NAVOPTHALSUPTRACT);

(f) Naval Medical Research and Development Command (NAVMEDRSHDEVCOM);

(g) Naval Aerospace Medical Institute (NAVAEROSPMEDINST).

c. BUMED exercises command and control over five healthcare support offices (HLTHCARE SUPPO or HSOs) which provide technical assistance to hospitals and clinics in healthcare delivery, quality assurance, resource management, and logistics support.

HSOs are located at Norfolk, VA; Jacksonville, FL; London, UK; Barbers Point, HI; and San Diego, CA.

d. BUMED also exercises command and control over the Fleet Hospital Support Office, Camp Pendleton, CA, and the Office of Medical and Dental Affairs, Great Lakes, IL. The Office of Medical and Dental Affairs provides fiscal support and

consolidates Navy claims processing for all active duty healthcare provided by the civilian sector.

e. Figure 3-1 displays the organizational structure of Navy medicine.

6. Conditions for Execution. Provision of medical support is required and expected under the conditions of peace, contingencies short of general war, and general war. BUMED and subordinate commands, in conjunction with assets of CINCs/CNET, will increase levels of readiness and response as directed by CNO.

7. Preparation and Maintenance. The command's POMI officer is responsible for the preparing and maintaining the LSMP. Additional new parts, chapters, sections, and articles are authorized to accommodate command information needs not satisfied within the standard format. However, such revisions shall also be submitted to the Chief, BUMED (ATTN: (MED-27), with a copy to CNO (ATTN: OP402) for coordination and incorporation into the standardized base planning document structure.

8. Subordinate Activity Plans. BUMED requires that each Echelon 3, 4, and 5 subordinate activity prepare and submit an LSMP to BUMED. The document shall be prepared in accordance with the guidance contained in this instruction. Plans should be fluid enough to be easily updated and continuously effective.

a. Claimancy 18 Echelon 3 through 5 activities will:

(1) Publish and promulgate supporting LSMPS not later than six months after receiving the BUMED LSMP 180 days after receipt;

(2) Coordinate their LSMPS with supported commands;

(3) Review their LSMP for possible changes at least annually. Plans will be updated every two years, or as CNO directs;

(4) Provide comments and recommendations to BUMED regarding the adequacy of the BUMED LSMP;

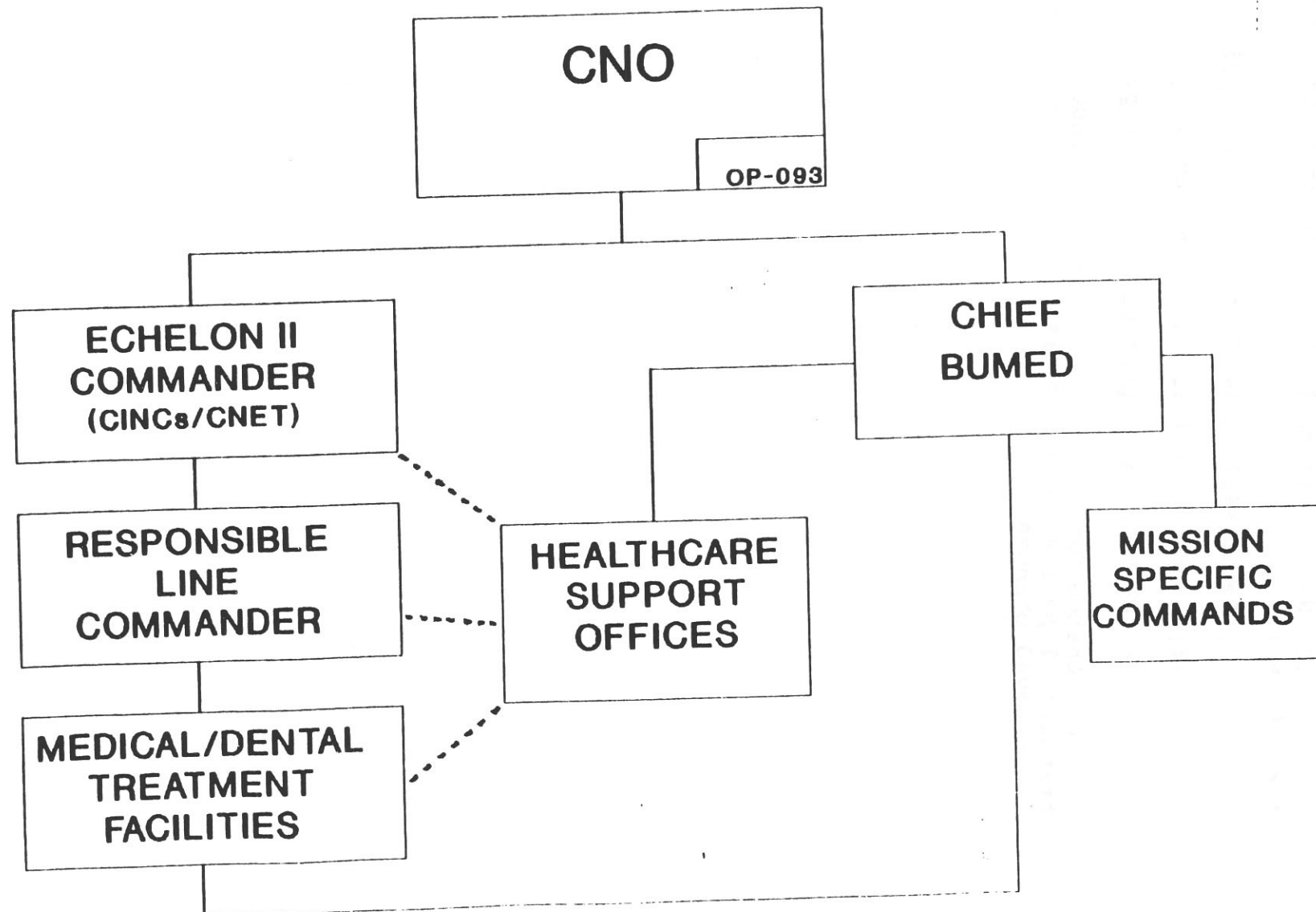
(5) Exercise portions of the LSMP, as appropriate, in conjunction with approved command post exercises (CPXs).

b. Minimum distribution for plan changes:

(1) BUMED (three copies);

FIGURE 3-1

NAVY MEDICINE ORGANIZATION



(2) Naval Medical Logistics Command, Ft. Detrick, MD
(two copies);

(3) Responsible Line Commander (one copy);

(4) Subordinate commands (one copy);

(5) Healthcare Support Office (one copy).

c. Change Data Protocol. BUMED will institute its change transmittal policy to inform plan recipients of approved or disapproved changes.

CHAPTER 4

ASSUMPTIONS

1. Responsibility. The responsibility for determining local assumptions rests with the Commanding Officer, who must ensure that only essential elements are defined as assumptions.

2. Augmentation/Mobilization Planning Assumptions

a. There will be some warning time; the day of mobilization (M-day) will be declared and will coincide with the start of deployment operations (C-day).

b. Partial mobilization will be a prelude to full mobilization.

c. Full mobilization will be a prelude to total mobilization.

d. The tactical situation in areas of operation subsequent to M-day will permit the US Air Force to evacuate casualties from the Amphibious Objective Area (AOA) to overseas safe haven or to CONUS.

e. Sources to provide required manpower will be Selected Reserves (SELRES), civilian personnel, contract services, partnership programs, CHAMPUS, and Individual Ready Reserve (IRR), the Standby Reserve 1 & 2, veteran volunteers, and retirees; and Selective Service System accessions (available in 90 days).

f. The Medical Personnel Unit Augmentation System (MPUAS) will be activated immediately, causing a loss of the majority of active duty healthcare personnel from CONUS MTFs and forcing the termination of healthcare services to non active-duty military patients.

g. Legislation and executive orders presently held in readiness will be activated or promulgated to provide authority for categories of mobilization to the degree required to meet the situation. Included in this standby readiness category is the securing of congressional authority to draft certain critically short medical specialists. Initial inputs from this source will be received about M+2 months.

h. Any situation requiring mobilization, other than one requiring selective mobilization, will be of sufficient gravity to extend Expiration of Terms of Service (ETS).

3. Manpower Planning Assumptions

a. No medical support will be available from line commanders.

b. After MPUAS requirements have been filled, nonmedical personnel may be taken by the line under the Emergency Fleet Augmentation Program (EFAP).

c. Contract support services in place will remain.

d. Healthcare manpower assets required for the period between MPUAS augmentation and the reporting for duty of healthcare SELRES is estimated to be about ten (10) days.

e. The number of civilian healthcare providers at medical activities would not rise significantly. Except for maintenance, food service, and clerical support personnel, the majority of civilian personnel are in the skilled to highly-skilled category and would not, in general, be available until M+60 to M+90.

f. A 60 hour workweek commences on M-Day and remains in effect for 2 months.

4. Logistics Planning Assumptions

a. Commitments for interservice/intraservice and allied foreign national combat-related workloads will be honored subject to assigned priorities.

b. Productivity rate (output per man-hour) will drop because of the lengthened work week.

c. Spare part support will not be sufficient to meet surge requirements.

d. All facilities now under Department of the Navy control and Coast Guard under the Department of Transportation will be available for Navy use.

e. Fleet commanders will ensure that Not Ready For Issue (NRFI) materiel begins to flow to CONUS not later than M+60.

f. Maximum effort will be made to ensure adequate medical materiel is available to support mobilization missions contained in this plan.

g. Sufficient storage and maintenance resources will exist to ensure protection of prepositioned war reserve materiel stocks (PWRMS) for medical facilities.

h. MINIMIZE will be declared during periods of mobilization and will provide relief in the use of existing communications systems.

i. Civilian nonindustrial facilities (motels, hotels, and colleges) will be made available pursuant to DoD Directive 3005.2.

j. Industrial operations will significantly increase:

(1) Inactive industrial facilities and production lines will be reopened;

(2) Increased numbers of workers will be engaged in occupations and operations in which they have not been fully trained.

k. When full or total mobilization is declared, the Planning, Programming, and Budgeting System (PPBS) will be replaced by an abbreviated system designed to provide physical facilities through new construction and facilities acquisition within 180 days of identifying the requirement.

l. Adequate funding will be provided to support the mobilization effort.

m. The availability of resupply through the Federal Supply System will initially be diminished by the drawdown of materiel in support of the operational forces.

n. Naval Medical Logistics Command is tasked with providing medical open purchase support, as needed, to overseas MTF/DTFs and for the T-AH Hospital Ship platforms.

5. Cadre Staffing Planning Assumptions

a. Cadre staffing is defined as the basic manpower requirement identified by quantity and mix of personnel to support CONUS MTF/DTFs following activation of the MPUAS and prior to arrival of SELRES and other backfill necessary to fully expand CONUS MTF/DTFs. This is estimated to be a ten day period. All CONUS MTF/DTFs need a support capability as defined by unit commanders relative to base mission and catchment area situation. They will maintain command and control, continuity of operations, and minimum required health service.

b. The cadre requirement for mission specific commands and their subordinate commands will not exceed peacetime authorizations.

6. Facility/Environmental Planning Assumptions

a. MTFs will continue to function per BUMEDINST 6321.3 as general, acute care hospitals. Expanded capacity will be oriented toward support of the eight Armed Services Medical Regulating Office (ASMRO) medical regulating categories. The number of beds supported and staffed in each category will be identified by the MTF. All bed capacity not in one of the wartime medical regulating

categories will be reviewed with emphasis toward inclusion in the wartime bed capability categories. (Note distinction between operating beds (staff and support) in contrast to simply manning bed space or beds available but not supported or staffed.)

b. Adequate building space to accommodate bed expansion will be available.

c. MTF/DTFs will also act as general, acute care treatment facilities supporting the mobilization of reserves.

d. Installation populations will increase because of increased workload, reception station processing, overseas replacement processing, recruit training activities, and industrial operations.

e. Inactive installations or portions of installations will be reopened. They may have inadequate utilities and may be infested with pest which are disease vectors.

f. At risk population's demand on water supply, sewerage systems, and solid waste disposal facilities will increase.

g. Families residing in the military communities will remain and additional families will arrive. The number and quality of accommodations may be inadequate and the local civilian community may not have an adequate supply. Such conditions will increase the risk of disease within the dependent population and surrounding civilian communities.

h. The National Disaster Medical System (NDMS) may be activated by the Department of Health and Human Services (DHHS) or FEMA for peacetime/natural disasters, when military casualty levels exceed the capability of the DoD and VA medical facilities, the NDMS may be activated by the ASD(HA). Chapter 18 discusses NDMS in detail.

i. By Executive Order, all federal hospitals in CONUS will participate in NDMS.

j. Activities designated as NDMS coordinating centers shall plan to accomplish their mission as casualty reception centers and for patient transportation within local areas.

7. Dental Planning Assumptions

a. All dental facilities will continue to function with acute care capability to include emergency treatment, examinations, preventive dentistry, and treatment of active duty dental class 3 patients.

b. Inactive dental facilities will be promptly activated and rehabilitated as necessary.

8. Health Services Support Assumptions

a. Upon activation of the Medical Personnel Unit Augmentation System (MPUAS), increased requirements for providing healthcare in Navy MTFs for active duty members will reduce appreciably the amount of healthcare available for other authorized categories of personnel. This change of emphasis will be reflected in the greatly increased use of civilian health services for those authorized under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) including, when ordered by DoD, suspension of the requirement for issuance of Statements of Nonavailability.

b. Health service support is available to remaining CONUS active duty personnel, civil service, and base operating support (BOS) for catchment area, and care of dependents in isolated areas.

c. Virtually all nonactive duty inpatients will be discharged or transferred to civilian facilities at M-day.

d. Inflow of casualties is expected to start before M+1 month.

e. Inpatient and outpatient care for all retirees and their dependents will be provided through civilian sources except for emergency referral care.

f. All elective care will be suspended.

9. Training Planning Assumptions

a. The cadre mission will include continuation of Graduate Medical Education (GME). GME 1 (internship program) continues. GME 2 (residency program) students in the last 50 percent of their training should be released to augmentation assignments; BUMED will make decision regarding GME students in first 50 percent of training - continue training or use as GMO augmentees. Accreditation Council for Graduate Medical Education (ACGME) standards relaxed.

b. The following critical specialty training programs will accept accessions and continue at peacetime (or greater) levels after mobilization: nurse anesthetists, flight surgeons, field medical service technicians (FMF corpsmen), and operating room technicians.

c. Existing community health nursing programs will be expanded, especially in the performance of home visits, disease surveillance, and discharge planning in order to reduce the burden on military hospitals and clinics.

10. Naval Reserve Planning Assumptions. The following HM NECs are not assignable by the SELRES community:

- 8294 Search and Rescue Medical Technician
- 8402 Nuclear Submarine Medical Technician
- 8406 Aerospace Medical Technician
- 8409 Aerospace Physiology Technician
- 8425 Surface Independent Duty Corpsman
- 8432 Preventive Medical Technician
- 8446 Otolaryngology Technician
- 8482 Pharmacy Technician
- 8485 Psychiatry Technician
- 8486 Urology Technician
- 8492 Special Operations Technician
- 8493 Medical Deep Sea Diving Technician
- 8495 Dermatology Technician
- 8703 Dental Administrative Technician
- 8472 Photo Technician

CHAPTER 5

MOBILIZATION PROCESS AND POLICIES

1. Responsibilities. The mobilization planning process is set forth in a wide variety of documents. BUMED, as the primary provider of healthcare for the DON, must be integrated with Navy planning.
2. Mission. The mission of Navy health services support is to preserve manpower by: (a) preventing disease and injury; (b) restoring functional health and well-being; (c) returning personnel to full duty as soon as possible; and, (d) minimizing disability. The peacetime role of Navy health services support is to provide effective healthcare services and to maintain a capability to rapidly support the operating forces with a highly trained and operationally oriented force capable of treating casualties in an integrated nuclear, biological, chemical, low intensity conflict (LIC), and conventional warfare environment.
3. Reference. The Manual of the Medical Department.
4. Policies and Procedures
 - a. Mobilization is preparing for war or other emergencies through assembling and organizing national resources. Mobilization is implemented over time and has defined levels throughout the period. The authority to mobilize rests with the President and Congress under the specific provisions of Title 10 United States Code (USC). The effectiveness by which a mobilization for emergency or war takes place is in direct proportion to the deliberate effort and participation conducted in the preparation phase. A plan is never complete until finally implemented. The planning process calls for a constant review, audit, development, and coordination effort to account for new guidance or dramatic changes in direction.
 - b. The review process is set into motion each January when the Secretary of Defense issues the Defense Planning Guidance (DPG). The guidance is implemented through two systems: the Planning, Programing, and Budgeting System (PPBS) and the Joint Strategic Planning System (JSPS). The planning process is a deliberate review so that commanders, staffs, and supporting commanders are provided an opportunity for input. The time invested in this process is critical for expeditious response in time of crisis.
 - c. Operations planning is conducted by the CINCs component commands, as well as the Services and Agencies.

5. Logistics Support and Mobilization Plan (LSMP)

a. The LSMP is the single, integrated, mobilization and deployment planning document for the Navy. The mobilization plans of major Navy commands and agencies as well as the NCMP constitute the Navy's plans for mobilization. The LSMP coordinates developing plans for medical and dental activities.

b. The LSMP, published in compliance with the NCMP, is for use down to the echelon 5 level. It is a ready reference for senior supervisors and will be used for mobilization planning within Navy. RLCs are encouraged to provide copies to the lowest echelon.

c. This document contains a description of the mobilization process, and the integrated systems that comprise it. The objective of the LSMP is to improve Navy participation in joint operations planning and Navy mobilization planning and execution. The intent is to provide clearly defined responsibilities, centralized planning and management, and a single source document for the promulgation of policies, guidance, and planning assumptions.

CHAPTER 6

MEDICAL/DENTAL CAPABILITIES

1. Purpose. This chapter identifies Navy CONUS and OCONUS health services support capabilities.

a. Effective medical/dental support for operating forces requires a continuum of care which extends from the forward edge of the forward line of own troops (FLOT) to CONUS. Two vital links in that continuum are the OCONUS and CONUS medical/dental treatment facilities. The former not only provides routine support to the operating forces but also, when augmented with additional personnel, provides additional critical casualty care. Figure 6-1 depicts the continuum of medical care for both the fleet and the Fleet Marine Force. Lower echelons of care are highly mobile with a very limited capability to provide extensive medical care. Higher echelons of care have a greater capability to provide medical care but will be less mobile. As depicted a casualty will flow from one facility to another through the next higher echelon until reaching that facility which can provide the required definitive care and allow the individual to return to duty or reaching a medical treatment facility in CONUS.

b. CONUS MTFs provide training, base support, medical personnel augmentation, supply support, and casualty care.

c. CONUS DTFs provide dental care to improve the dental readiness of deploying forces.

d. Comprehensive health services support also requires mission-specific support commands. These commands are vital in providing such services as ophthalmic, materiel, training, research and development, and environmental health capabilities.

2. Medical/Dental Facilities. Figure 6-2 provides a listing of Navy fixed CONUS and OCONUS MED/DTFs and mission specific commands.

3. Fixed MTF Bed Capacity. BUMEDINST 6321.3.

a. Determination. To meet mission requirements for hospital beds, flow through beds organic to the USMC and amphibious ships are not considered because they must be kept available for incoming casualties. These beds are emptied as soon as the patient is stable.

b. Bed Capacity. The number of beds a hospital can accommodate. This definition refers to space and not equipment

Figure 6-1

CONTINUUM OF CARE

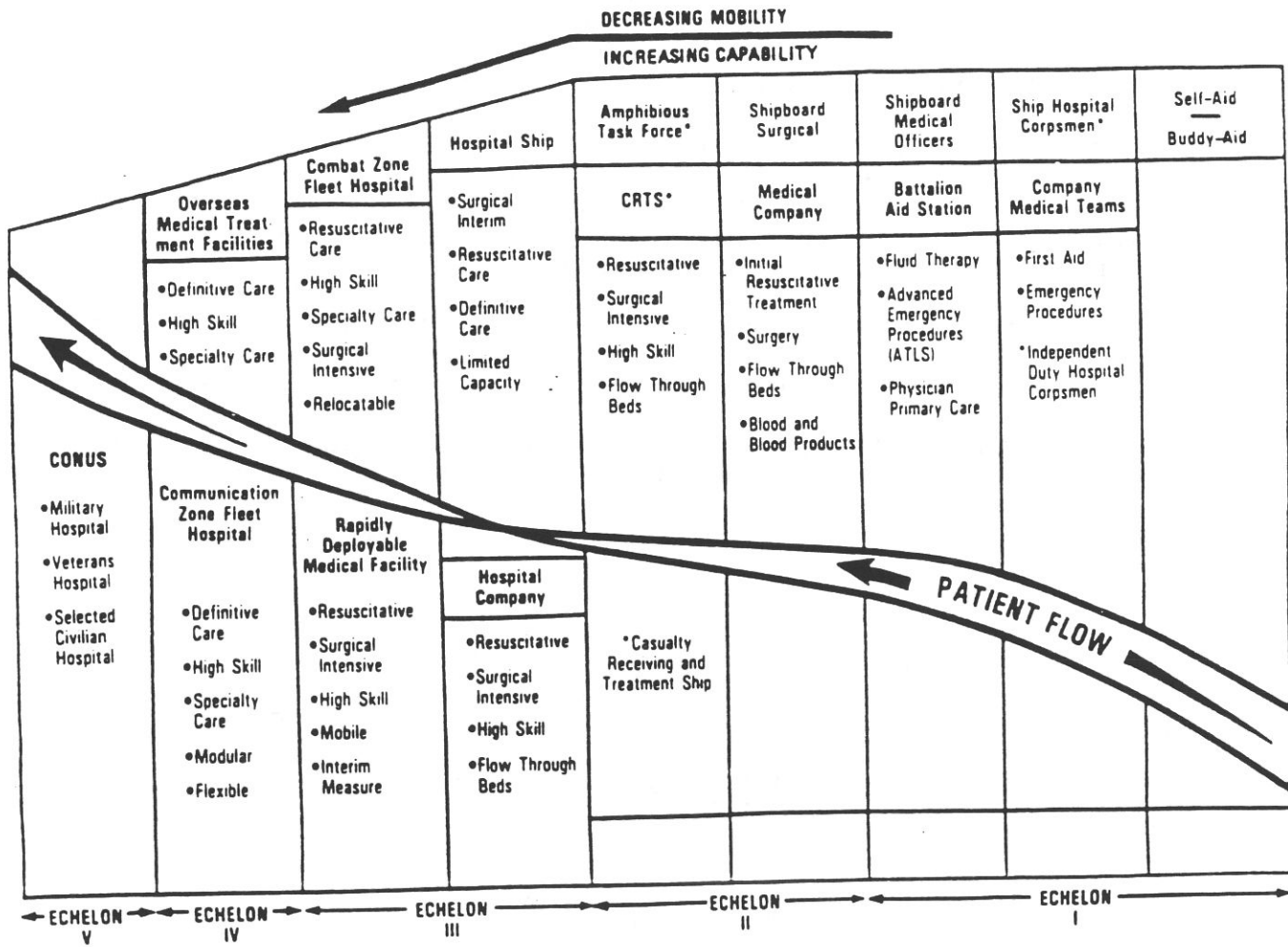


Figure 6-2

NAVAL MEDICAL AND DENTAL ACTIVITIES

Bureau of Medicine and Surgery, Washington, DC

Healthcare Support Offices

Norfolk, VA
Jacksonville, FL
San Diego, CA
Barbers Pt, HI
London, UK

Office of Medical/Dental Affairs

Great Lakes, IL (Fiscal Support)

Naval Medical Treatment Facilities - OCONUS

BR Hosp Adak
USNH Guam
USNH Guantanamo Bay
USNH Keflavik
USNH Naples
USNH Okinawa
USNH Roosevelt Roads
USNH Rota
BR Hosp Sigonella
USNH Subic Bay
USNH Yokosuka
BR MEDCL Iwakuni (Not a hospital, but has bed capacity)

Naval Medical Treatment Facilities - CONUS

A. Multiple Graduate Medical Education

NNMC Bethesda
NH Oakland
NH Portsmouth
NH San Diego

B. Family Practice Graduate Medical Education

NH Bremerton
NH Camp Pendleton
NH Charleston
NH Jacksonville
NH Pensacola
BR Hosp Gulfport

Figure 6-2 (continued)

C. Isolated

NH Lemoore
NH Twentynine Palms

D. Other Hospitals

NH Beaufort
NH Camp Lejeune
NH Cherry Point
NH Corpus Christi
NH Great Lakes
MED BRCL NTC Great Lakes (Not a hospital, but has
bed capacity)
NH Groton
NH Long Beach
MED BRCL China Lake (Not a hospital, but has bed
capacity)
NH Millington
NH Newport
NH Oak Harbor
NH Orlando
NH Patuxent River
NH Philadelphia

Naval Medical Clinics - CONUS

Annapolis, MD
Key West, FL
New Orleans, LA
Norfolk, VA
Port Hueneme, CA
Portsmouth, NH
Quantico, VA
MED BRCL San Diego, CA
MED BRCL San Francisco, CA
Seattle, WA
MED BRCL Washington, DC

Naval Medical Clinics - OCONUS

London, UK
Pearl Harbor, HI

Figure 6-2 (continued)

Naval Dental Clinics - CONUS

NNDC Bethesda, MD
Bremerton, WA
Camp Lejeune, NC
Camp Pendleton, CA
Charleston, SC
Great Lakes, IL
Jacksonville, FL
Long Beach, CA
Newport, RI
Norfolk, VA
Orlando, FL
Parris Island, SC
Pensacola, FL
Philadelphia, PA
San Diego, CA
San Francisco, CA

Naval Dental Clinics - OCONUS

Yokosuka, Japan
Roosevelt Roads, Puerto Rico
Okinawa, Japan
Pearl Harbor, HI
Naples, Italy
Guam, MI
Subic Bay, RP

Mission Specific Commands

A. Navy Environmental Health Center - Norfolk, VA

- Navy Preventive Medicine Units

Unit #2, Norfolk, VA
Unit #5, San Diego, CA
Unit #6, Pearl Harbor, HI
Unit #7, Naples, Italy

- Navy Disease Vector Ecology and Control Centers

Alameda, CA
Jacksonville, FL

Figure 6-2 (continued)

- Navy Drug Screening Laboratories

Jacksonville, FL
Great Lakes, IL
Norfolk, VA
Oakland, CA
San Diego, CA

B. Naval Aerospace Medical Institute, Pensacola, FL

C. Naval Health Sciences Education and Training
Command, Bethesda, MD

- Naval Hospital Corps Schools

Great Lakes, IL
San Diego, CA

- Naval School of Health Sciences

Bethesda, MD
San Diego, CA

D. Naval Ophthalmic Support and Training Activity,
Yorktown, VA

E. Naval Medical Research and Development Command, Bethesda,
MD

- Naval Aerospace Medical Research Laboratory,
Pensacola, FL

- Naval Biodynamics Laboratory, New Orleans, LA

- Naval Blood Research Laboratory, Boston, MA

- Naval Dental Research Institute, Great Lakes, IL

- Naval Health Research Center, San Diego, CA

- Naval Submarine Medical Research Laboratory,
New London, CT

- Naval Medical Research Institute, Bethesda, MD

Unit #2, Manila, Republic of the Philippines
Unit #2 Detachment, Jakarta, Indonesia
Unit #3, Cairo, Egypt
Unit Detachment, Lima, Peru
Toxicology Detachment, Wright Patterson
AFT, OH

Figure 6-2 (continued)

F. Naval Medical Data Service Center, Bethesda, MD

G. Naval Medical Logistics Command, Fort Detrick, MD

U.S. Naval Units at Army Commands

Naval Medical Administrative Unit, Army Tripler
General Hospital, Honolulu, HI

and staff capability. Former ward or room space which has been altered and not readily reconverted is not included in calculating bed capacity. Space for beds used only in connection with examinations or brief treatment periods, such as in examining rooms or in the physical therapy department, is not included. Nursery space is not included but is accounted for separately based on the number of bassinets the nursery can accommodate.

(1) Normal Bed Capacity. The number of beds which can be used in an area, with approximately 140 to 200 square feet of space per bed. For cantonment-type hospitals still in use, bed capacity may be measured in the number of beds which can be spaced on 8-foot centers.

(2) Expanded Bed Capacity. The number of beds which can be used in wards or rooms designed for patients' beds. Beds are spaced on 6-foot centers (approximately 72 square feet per bed).

(3) Mobilization and Contingency Bed Capacity. The total of the expanded bed capacity plus the number of beds which can be set up in areas not originally designed for patient care, such as troop billets, hotels, motels, and schools, and in former patient care areas that can be reconverted within the time of hospital's mobilization and contingency mission.

c. Licensed Beds. The number of beds a hospital is licensed, certified, or otherwise authorized and has the ability to operate; i.e., space, equipment, medical materiel, and ancillary and support services have been provided, but the required staff is not necessarily available. Licensed beds equal the sum of operating beds and set-up beds. Because this term takes into account equipment, the number of licensed beds cannot exceed the normal bed capacity.

(1) Operating Bed. Beds currently set up and ready in all respects for patient care: includes supporting space, equipment, medical materiel, ancillary and support services, and staff to operate under normal circumstances.

(2) Set-Up Bed. A bed that is ready, in all respects, except for the availability of staff, for the care of a patient; that is, space, equipment, medical materiel, and ancillary and support services have been provided, but the bed is not staffed to operate under normal circumstances.

d. Bed Capacity and Licensed Beds Statistics (FY 1990).

	CONUS	OCONUS
Normal Bed Capacity	7,030	1,317
Expanded Bed Capacity	8,823	1,769
Mob/Cont Bed Capacity	10,216	2,406
Licensed Beds	5,371	963
Operating Beds	3,361	466
Set-Up Beds	2,010	497

e. Detailed statistics of bed capacity and licensed beds for each medical treatment facility are in Table 6-2.

4. Rapidly Deployable Medical Facility (RDMF)

a. The RDMF is an austere, 1000 bed, combat casualty care assembly consisting of four 250-bed combat zone hospitals, each with six operating tables. The modular hospitals can be used independently or in multiples as operational requirements may dictate. Each hospital is equipped for surgically intense casualty flow and is self-sustaining for 30 days. Resupply is accomplished through normal supply distribution channels. Each hospital has the normal operating daily capability to perform the following in 24 hours:

Major Surgical Procedures -	36
Admissions -	65
Outpatient Visits -	150
Casualty Holding Period -	72-96 hours

b. The RDMF is rapidly deployable, readily erectable, and relocatable. Local, post-debarkation positioning, erection, and establishment of hospital operations can be accomplished within 48 hours using the organic table of equipment. Relocation and reestablishment (excluding travel time) can be accomplished in a similar period of time.

Figure 6-3
BED CAPACITY AND LICENSED BEDS FOR FY 1990

	NORMAL BED CAPACITY	EXPANDED BED CAPACITY	MOB/CONT BED CAPACITY
<u>OCONUS</u>			
USBRHOSP ADAK	15	17	17
USNH GUAM	247	306	442
USNH GUANTANAMO B	102	128	128
USNH KEFLAVIK	17	25	25
USNH NAPLES	26	35	166
USNH ROOSEVELT R	118	128	128
USNH ROTA	58	80	419
USBRHOSP SIGNONELLA	9	12	12
USNH SUBIC BAY	116	143	171
USNH YOKOSUKA	146	234	237
USBRCL IWAKUNI	9	23	23
SUBTOTAL (OCONUS)	1,317	1,769	2,406
<u>CONUS</u>			
NH BEAUFORT	207	247	247
NNMC BETHESDA	629	779	779
NH BREMERTON	281	600	645
NH CAMP LEJEUNE	265	284	284
NH CAMP PENDLETON	281	600	645
NH CHARLESTON	318	360	517
NH CHERRY POINT	111	129	129
NH CORPUS CHRISTI	195	195	195
NH GREAT LAKES	690	887	887
NTC GREAT LAKES	81	128	128
NH GROTON	124	133	133
BRHOSP GULFPORT	60	60	60
NH JACKSONVILLE	385	496	496
NH LEMOORE	69	99	99
NH LONG BEACH	569	692	692
BRCL CHINA LAKE	10	11	11
NH MILLINGTON	140	183	236
NH NEWPORT	174	239	239
NH OAK HARBOR	38	38	38
NH OAKLAND	611	728	879
NH ORLANDO	153	158	158
NH PAXTUXENT RIVER	30	30	32
NH PENSACOLA	275	342	342
NH PHILADELPHIA	97	133	133
NH PORTSMOUTH	555	873	873
NH SAN DIEGO	761	761	1,735
NH TWENTYNINE PALMS	29	29	40
SUBTOTAL CONUS	7,030	8,823	10,216

c. Within the overall continuum of care for health services support, the RDMF is suitable for physical placement within the supported commander's area of responsibility consistent with Navy and Marine Corps force deployment. Casualty flow would normally come from medical battalion assets, Force Service Support Group (FSSG), and Marine Expeditionary Force (MEF). Even though a combat zone medical facility, male and female medical personnel will be assigned. Active duty staffing will come from multiple CONUS MTFs.

5. Hospital Ship (T-AH). The hospital ship is an afloat, surgically intense, acute care hospital. The primary mission of this ship is to provide support for Marine Corps and fleet combat operations. The hospital ship is essential for combat zone care, particularly in the early stages of an amphibious assault. The hospital ship capability is equal to communication zone fleet hospitals; this capability, coupled with the inherent mobility of the ship and the flexibility in levels of care, provides a valuable asset during combat operations. There two ships, each containing 12 operating rooms and 1,000 beds. In total, these beds provide the hospital ship with an acute care facility ranging from intensive care to moderate, light, and even self-care.

a. The two hospital ships are equipped as follows:

ASSETS

ICU BEDS	100
Intermediate Beds	400
Minimal Care Beds	500
TOTAL BEDS	1000
OPERATING ROOMS	12
ADMISSIONS PER DAY	200

b. The USNS MERCY (T-AH 19) is layberthed at NSC Oakland, CA and the USNS COMFORT (T-AH 20) is layberthed at Baltimore, MD.

6. Fleet Hospitals

a. Fleet hospitals are shore-based, multi-specialty, surgically intensive facilities. Because of varying physical configurations (e.g., TEMPER tents as well as rigid structures), fleet hospitals can be located in the combat or communication

zones of the theater of operations. In addition, they may be located at other overseas, non-theater areas along the lines of communication. As currently proposed, the Fleet Hospital Program will ultimately consist of 17 fleet hospitals with a total capacity of 7,750 beds. Staffing will be a mix of active and reserve personnel, depending upon initial operating capability (IOC) requirements. The fleet hospitals have been allocated to CINCUSNAVEUR, CINCLANTFLT, and CINPACFLT.

b. There are three types of fleet hospitals with configurations and assets as follows:

Type	Number of Beds	Zone	Operating Room Tables	Number of Physicians per Hospital
1	250	CBTZ	4	48
2	500	CBTZ	6	69
3	500	COMZ	6	76

7. Casualty Receiving and Treatment Ships (CRTS)

a. After troop debarkation from amphibious ships, LHD/LHA/LPH class ships expand their medical capacities to support the landing force. Because the primary mission of amphibious ships is to transport troops, a CRTS may only receive casualties during a period before moving to another location. After initial treatment, patients aboard CRTSs are moved to a definitive care MTF when possible.

b. CRTS Capabilities:

Ship Type	No. Ships	ICU Beds	Ward Beds	Quiet Room	Overflow Beds	OR's	Physicians Peace/War
LHA	5	17	48	44	250-300	4	1/16
LPH	7	2	14	2	175-200	2	1/11
LHD	1	17	41	4	500-550	6	2/26

c. Listing of Amphibious Helo/Landing Craft Carriers:

(1) TARAWA (LHA)

(2) SAIPAN (LHA)

- (3) BELLEAU WOOD (LHA)
- (4) NASSAU (LHA)
- (5) PELELIU (LHA)
- (6) IWO JIMA (LPH)
- (7) OKINAWA (LPH)
- (8) GUADALCANAL (LPH)
- (9) GUAM (LPH)
- (10) TROPOLI (LPH)
- (11) NEW ORLEANS (LPH)
- (12) INCHON (LPH)
- (13) WASP (LHD)

8. Fleet Marine Force Medical Battalion. Each Marine Expeditionary Force (MEF) includes an FMF Medical Battalion with 540 beds; 60 beds and 2 operating rooms (ORs) in each of the 4 collecting and clearing companies and 150 beds and 5 ORs in the two surgical support companies.

9. CONUS and OCONUS Dental Activities Capabilities. Shore-based dental facilities provide dental service to Navy and Marine Corps personnel and are defined by the following categories:

CATEGORY	DEFINITION
I	Dental Treatment Room (DTR) that is functional and staffed with Claimant 18 staff.
II	DTR that is functional but unused due to unavailable claimant 18 staff.
III	DTR not setup but can be functional within 5 working days. Equipment is available, functional, and on board.
IV	DTR not setup but utility service center in place and DTR could be functional within 5 working dates IF functional equipment or parts were made available and/or on board.

Facilities available for planning, based on the number of DTR,
are as follows:

CONUS DENTAL DEPARTMENTS

DEPARTMENT	CAT I	CAT II	CAT III	CAT IV
NH BETHESDA	20	0	0	0
NH BEAUFORT	3	0	0	0
NH BREMERTON	2	2	0	0
NH CAMP LEJEUNE	11	10	0	0
NH CAMP PENDLETON	6	1	0	0
NH CHARLESTON	2	2	0	1
NH CHERRY POINT	1	0	0	0
NH GREAT LAKES	10	0	0	0
NH GROTON	2	0	0	0
NH JACKSONVILLE	2	2	0	0
NH LONG BEACH	4	0	0	0
NH MEMPHIS	2	0	0	0
NH NEWPORT	3	0	0	0
NH OAKLAND	14	0	0	0
NH ORLANDO	4	0	0	0
NH PENSACOLA	4	0	0	0
NH PHILADELPHIA	4	0	0	0
NH PORTSMOUTH VA	13	0	0	0
NH SAN DIEGO	12	0	0	0

CONUS DENTAL CLINICS

ACTIVITY	CAT I	CAT II	CAT III	CAT IV
NDC BETHESDA	181	0	0	14
NDC BREMERTON	42	13	4	2
NDC CP LEJEUNE	104	1	0	2
NDC CP PENDLETON	129	23	1	0
NDC CHARLESTON	29	0	0	6
NDC GREAT LAKES	100	0	8	3
NDC JACKSONVILLE	75	0	0	0
NDC LONG BEACH	69	5	0	2
NDC NEWPORT	65	6	1	0
NDC NORFOLK	226	17	0	0
NDC ORLANDO	67	10	0	14
NDC PARRIS IS	64	0	0	5
NDC PENSACOLA	79	54	0	5
NDC PHILADELPHIA	24	0	0	0
NDC SAN DIEGO	212	39	11	27
NDC SAN FRANCISCO	42	49	0	20

OCONUS DENTAL DEPARTMENTS

DEPARTMENT	CAT I	CAT II	CAT III	CAT IV
NH GUAM	3	1	0	0
NH OKINAWA	4	0	0	0
NH ROOSEVELT ROADS	2	0	0	0
NH SUBIC BAY	1	1	0	0

OCONUS NAVAL DENTAL CLINICS

ACTIVITY	CAT I	CAT II	CAT III	CAT IV
NDC GUAM	19	2	0	1
NDC NAPLES	60	3	1	0
NDC OKINAWA	23	63	1	3
NDC PEARL HARBOR	50	42	2	0
NDC SUBIC BAY	26	0	0	0
NDC YOKOSUKA	64	0	6	0
NDC ROOSEVELT ROADS	11	2	2	0

10. Subordinate Command Responsibilities. Affected medical and dental facilities:

a. Shall validate all capacity and capability totals contained in this chapter. Mission specific support commands shall identify their current capability as well as normal and expanded capacity.

b. Develop detailed plans and procedures to accomplish both a rapid reduction in operating capability and service, and rapid expansion to maximum capacity.

c. Identify facility constraints which would prohibit rapid expansion to maximum capacity. Consider ancillary support functions, storage space, physical renovations, staff berthing, messing, etc. Address alternatives to remedy physical plan and shortfalls; prepare formal MILCON requests if consistent with planning guidance.

d. Explore options for patient care should the casualty workload exceed maximum capacity. Consideration should be given to identifying nonmedical base assets which might be suitable for use as casualty overflow space or storage space. Mission-specific commands shall also explore options should workload requirements exceed maximum capacity.

CHAPTER 7

MANPOWER AND PERSONNEL MANAGEMENT

1. Introduction. Navy manpower and personnel mobilization policies and procedures are key to effective logistics support and mobilization planning. This chapter provides general information on Navy manpower mobilization and personnel policies. Subsequent chapters will provide LSMP users with concepts of the three major components comprising manpower and personnel management - the Medical Personnel Unit Augmentation System (MPUAS), the Naval Reserve program, and civilian personnel.

2. Reference

- a. OPNAVINST 1000.16G
- b. DoD Medical Staffing Guidelines

3. General Policy

a. Mobilization requirements are listed in the Manpower Authorization. Updating your mobilization requirements to reflect updated mobilization billet/position requirements identified in the LSMP, should be done during the Efficiency Review process and changes submitted via the manpower authorization change request as directed in OPNAV INST 1000.16G. Without a periodic alignment of the medical activity's MPA to reflect LSMP requirements, CNO and the medical activity's commanding officer will be operating from different sets of manpower mobilization requirements.

b. The manpower requirements identified in the activity's LSMP, after validation by BUMED, will coincide with the manpower requirements stated in the Navy Manpower Mobilization System (HMIS), the activity's billet file, and MPUAS.

c. The necessity and importance for each medical and dental activity to update its manpower authorization (MPA) in conjunction with their LSMP review/revision cannot be overstated.

4. Manpower Authorization. Approved manpower authorizations of medical/dental activities reflect current allowances and organizational manning requirements for M-Day through M+12 in accordance with OPNAVINST 1000.16G. Although not detailed herein for each activity, these authorizations, particularly the mobilization requirements identified at M+1 through M+12, are an

integral part of the BUMED logistic support and mobilization planning process. MPAs must be thoroughly reviewed at least annually. They not only represent the manpower necessary to accomplish an assigned mission, but also provide an approximation of available manpower skills to support contingency-related operations.

a. Planners must be mindful when performing a manpower authorization review that the generated requirements accurately reflect the assigned mission of the command.

b. The MPA should identify:

- (1) Manpower requirements to expand the facility
- (2) Cadre staff requirements
- (3) Civilian and contractors personnel requirements
- (4) Existing SELRES available to fill mobilization requirements.

c. DoD and Navy medical staffing guidelines are ready references for estimating the appropriate mix of manpower required to perform a particular function based on the activity's projected workload.

5. Cadre Staff. Cadre staff is defined as the basic manpower requirement identified in terms of numbers and types of personnel to support CONUS treatment facilities (MTF/DTFs) following activation of MPUAS and prior to arrival of SELRES and other backfill (M+10 Days). SELRES are not to be counted as meeting cadre requirements. Selected Reservists are to supplement or backfill the cadre staff for expansion of the MTF/DTF. The cadre staff's mission is:

a. Maintain level of care capability essential to support active duty personnel in the catchment area.

b. Provide care to dependents in isolated areas.

c. Complete training of interns.

6. Responsibilities. Manpower planners at MTFs and DTFs are responsible for the following actions:

a. Review and identify total manpower requirements (active duty and reserve by specialty, civilian personnel, and contract personnel) to operate at expanded capacity for: M+1, M+2, M+3, M+6, and M+12.

b. Identify active duty cadre staff requirements taking into consideration civilian and contractor manpower.

c. Provide capabilities assessment for M+1, M+2, and M+3 billets to determine:

(1) The maximum activity capability assuming a 40-hour, 5-day workweek.

(2) The maximum activity capability assuming a minimum 60-hour, 6-day workweek (M+1 through M+2).

(3) The maximum activity capability assuming a minimum 48-hour, 6-day workweek (M+3)

d. Review MPA's at least annually.

CHAPTER 8

MEDICAL PERSONNEL UNIT AUGMENTATION SYSTEM (MPUAS)

1. Introduction. MPUAS provides active duty medical department personnel to augment operational and medical support units deploying in situations ranging from limited contingencies to global warfare. Peacetime medical manning levels of the FMF, CRTSS and OCONUS MTFs/DTFs are maintained below combat operational manning levels because of the difference between peacetime and combat medical workload. Deployable medical systems such as fleet hospitals and RDMFs have no staffing in peacetime; the T-AHs maintain only a cadre crew during peacetime. MPUAS receives and monitors the augmentation requirements of these platforms and provides previously identified and trained personnel required to meet operational manning levels.

2. References

- a. BUMEDINST 6440.5
- b. OPNAVINST S3061.1
- c. SECNAVINST 1300.13
- d. NWP 6 Series
- e. OPNAVINST 3061.2
- f. NAVMEDCOMINST 6440.2
- g. NAVMEDCOMINST 1500.8
- h. NAVPERS 15665E
- i. MCO P10120.28E
- j. NAVMEDCOMINST 4080.1
- k. OPNAVINST 5510.1H
- l. Communications Security Material Systems Manual 4K
- m. MILPERSMAN Article 5030120

3. Platforms

a. The following represent the current assets requiring medical augmentees. The noted platforms are listed in priority order to assist with refining mobilization plans. Percents

listed refer to the manning level target for the platform listed relative to critical specialists. Critical specialists are anesthesiologists, general surgeons, neurosurgeons, orthopedic surgeons, operating room nurses, nurse anesthetists, and operating room technicians.

SYSTEM/PLATFORM

MOBILIZATION MANNING LEVEL
FOR CRITICAL SPECIALISTS

Fleet Marine Force	100%
Casualty Receiving/Treatment Ships	100%
Hospital Ships (First priority for Bethesda and Oakland)	100%
RDMF Air Deployable Unit	100%
Fleet Hospitals 3, 5, 6, and 15	90%
OCONUS MTFs	90%
RDMF	90%
Fleet Hospitals 1, 2, 4, and 8	75%

b. CONUS Navy Medical Treatment Facilities. Although the above augmentation requirements will rapidly deplete the capability of Navy CONUS MTFs, remaining active duty combined with civilian and contract personnel are expected to provide the maximum level of services possible for active duty and returning casualties; they will contribute to the numbers of required skills of the cadre. Depending on the category of mobilization, SELRES, retirees, veteran volunteers and eventually draftees will become available to reestablish Navy CONUS medical and dental capability. The goal is to expand the capability of all Navy CONUS facilities to their maximum capacity.

4. Assignment Substitution List. In the MPUAS the requirements for some specialties exceeds the supply of appropriately trained individuals in the CONUS manpower base. Table 8-1 specifies subspecialty substitution criteria. To avoid potential

MEDICAL PERSONNEL UNIT AUGMENTATION SYSTEM
TABLE LISTING
SUBSTITUTION NOBC/NEC TABLE

NOBC/ NEC	VALID SUBST	TITLE	SUB TITLE	COMMENTS
0000	8XXX	GENERAL DUTY TECHNICIAN	HOSPITAL CORPSMAN TECHNICIAN - ANY	ANY HM NEC
0002	08XX	MEDICAL DEPARTMENT STAFF OFFICER	STAFF MEDICAL SERVICE CORPS OFFICER	ANY 23XX WITH APPROPRIATE EXPERIENCE
0005	0915	DIRECTOR OF NURSING SERVICE	NURSING SERVICE ADMIN	
0008	01XX	REGIONAL HEALTH CARE COORDINATOR	MEDICAL OFFICER SPECIALTY	ANY 21XX WITH APPROPRIATE EXPERIENCE
0016	01XX	CHIEF OF CLINICAL SERVICES	MEDICAL OFFICER SPECIALTY	ANY 21XX WITH APPROPRIATE EXPERIENCE
0020	01XX	CHIEF OF SERVICE	MEDICAL OFFICER SPECIALTY	ANY 21XX WITH APPROPRIATE EXPERIENCE
0020	0920	NURSING SERVICE ADMINISTRATOR	PATIENT CARE COORDINATOR	
0051	0101	EMERGENCY MEDICINE	INTERNAL MEDICINE	
0051	0102	EMERGENCY MEDICINE	PRIMARY CARE	MUST HAVE AQD 6LG AND 6LH
0051	0107	EMERGENCY MEDICINE	UNDERSEA MEDICINE	MUST HAVE AQD 6LG AND 6LH
0051	0108	EMERGENCY MEDICINE	FAMILY PRACTICE	
0051	0110	EMERGENCY MEDICINE	FLIGHT SURGEON	MUST HAVE AQD 6LG AND 6LH
0051	0118	EMERGENCY MEDICINE	ANESTHESIOLOGIST	
0051	0214	EMERGENCY MEDICINE	GENERAL SURGERY	
0101	0051	INTERNIST	EMERGENCY MEDICINE	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0101	0105	INTERNIST	PEDIATRICIAN	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0101	0107	INTERNIST	UNDERSEA MEDICINE	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0101	0108	INTERNIST	FAMILY PRACTICE	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0101	0110	INTERNIST	FLIGHT SURGEON	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0102	0051	PRIMARY CARE MEDICAL OFFICER	EMERGENCY MEDICINE	
0102	0101	PRIMARY CARE	INTERNAL MEDICINE	
0102	0105	PRIMARY CARE	PEDIATRICIAN	
0102	0108	PRIMARY CARE	FAMILY PRACTICE	
0102	0111	PRIMARY CARE	DERMATOLOGIST	
0102	0121	PRIMARY CARE	NEUROLOGIST	
0102	7542	PRIMARY CARE	PHYSICIAN'S ASSISTANT	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0105	0101	PEDIATRICIAN	INTERNAL MEDICINE	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0105	0102	PEDIATRICIAN	PRIMARY CARE	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0105	0107	PEDIATRICIAN	UNDERSEA MEDICINE	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0105	0108	PEDIATRICIAN	FAMILY PRACTICE	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0105	0110	PEDIATRICIAN	FLIGHT SURGEON	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY

MEDICAL PERSONNEL UNIT AUGMENTATION SYSTEM
TABLE LISTING
SUBSTITUTION NOBC/NEC TABLE

NOBC/ NEC	VALID SUBST	TITLE	SUB TITLE	COMMENTS
0108	0051	FAMILY PRACTITIONER	EMERGENCY MEDICINE	
0108	0101	FAMILY PRACTICE	INTERNAL MEDICINE	
0108	0105	FAMILY PRACTICE	PEDIATRICIAN	
0111	0101	DERMATOLOGIST	INTERNAL MEDICINE	
0111	0102	DERMATOLOGIST	PRIMARY CARE	
0111	0105	DERMATOLOGIST	PEDIATRICIAN	
0111	0108	DERMATOLOGIST	FAMILY PRACTICE	
0113	8425	PHYSICIAN'S ASSISTANT	ADVANCED HOSPITAL CORPSMAN	
0115	0102	PSYCHIATRIST	PRIMARY CARE	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0115	0108	PSYCHIATRIST	FAMILY PRACTICE	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0115	0110	PSYCHIATRIST	FLIGHT SURGEON	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0115	0121	PSYCHIATRIST	NEUROLOGIST	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0115	0163	PSYCHIATRIST	PREVENTATIVE MEDICINE (AERO)	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0118	0106	ANESTHESIOLOGIST	ANESTHESIOLOGIST RESIDENT	COMPLETED 2 YRS ANES TRNG NOT ASSIGNED INDEPENDENT
0118	0550	ANESTHESIOLOGIST	ORAL SURGEON	MIN 3 MO FORMAL TRAINING W/IN LAST 5 YRS; NOT IND
0118	0952	ANESTHESIOLOGIST	NURSE ANESTHETIST	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0121	0101	NEUROLOGIST	INTERNAL MEDICINE	
0121	0108	NEUROLOGIST	FAMILY PRACTICE	
0121	0115	NEUROLOGIST	PSYCHIATRIST	
0131	0107	RADIOLOGIST (DIAGNOSTIC)	UNDERSEA MEDICINE	NOT TO BE ASSIGNED INDEPENDENTLY
0131	0163	RADIOLOGIST (DIAGNOSTIC)	PREVENTIVE MEDICINE (AERO)	NOT TO BE ASSIGNED INDEPENDENTLY
0154	0158	PATHOLOGIST (ANAT. AND CLINICAL)	PATHOLOGIST (CLINICAL)	
0158	0154	PATHOLOGIST (CLINICAL)	PATHOLOGIST (ANALYTICAL)	
0160	0101	PREVENTIVE MEDICINE (GEN)	INTERNAL MEDICINE	
0160	0105	PREVENTIVE MEDICINE (GENERAL)	PEDIATRICIAN	
0160	0108	PREVENTIVE MEDICINE (GEN)	FAMILY PRACTICE	
0160	0163	PREVENTIVE MEDICINE (GENERAL)	PREV MEDICINE (AERO)	
0160	0166	PREVENTIVE MEDICINE OFFICER (GENERAL)	PREVENTIVE MEDICINE (OCCUPATIONAL)	
0163	0101	PREVENTIVE MEDICINE (AERO)	INTERNAL MEDICINE	AQD 6AF
0163	0108	PREVENTIVE MEDICINE (AERO)	FAMILY PRACTICE	AQD 6AF
0163	0110	PREV MED OFFICER (AEROSPACE)	FLIGHT SURGEON	AQD 6AF
0166	0101	PREVENTIVE MEDICINE (OCC)	INTERNAL MEDICINE	
0166	0107	PREVENTIVE MEDICINE (OCCUPATIONAL)	UNDERSEA MEDICINE	
0166	0107	PREVENTIVE MEDICINE (OCC)	FLIGHT SURGEON	
0166	0160	PREV MED OFFICER (OCCUPATIONAL)	PREV MEDICINE (GENERAL)	

MEDICAL PERSONNEL UNIT AUGMENTATION SYSTEM
TABLE LISTING
SUBSTITUTION NOBC/NEC TABLE

NOBC/ NEC	VALID SUBST	TITLE	SUB TITLE	COMMENTS
0166	0163	PREVENTIVE MEDICINE (OCCUPATIONAL)	PREV MEDICINE (AERO)	
0214	0106	GENERAL SURGEON	RESIDENT (0214,0229,0264,0269)	W/2 YRS SURGICAL TRAINING NOT IND
0214	0229	GENERAL SURGEON	OBSTETRICS/GYNECOLOGY	IF GEN SURG TRAINED; NOT INDEPENDENTLY ASSIGNED
0214	0254	GENERAL SURGEON	PLASTIC SURGEON	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0214	0264	GENERAL SURGEON	CT SURGEON	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0214	0269	GENERAL SURGEON	UROLOGIST	IF GEN SURG TRAINED; NOT INDEPENDENTLY ASSIGNED
0224	0106	NEUROSURGEON	NEUROSURGICAL RESIDENT	W/3 YRS TRAINING NOT ASSIGN INDEPENDENT
0229	0101	OBSTETRICS/GYNECOLOGY	INTERNAL MEDICINE	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0229	0102	OBSTETRICS/GYNECOLOGY	PRIMARY CARE	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0229	0108	OBSTETRICS/GYNECOLOGY	FAMILY PRACTICE	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0234	0249	OPHTHALMOLOGIST	OTOLARYNGOLOGY	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0244	0106	ORTHOPEDIC SURGEON	ORTHO RESIDENT	W/2 YRS ORTHO TRAINING NOT INDEPENDENT
0244	0214	ORTHOPEDIC SURGEON	GENERAL SURGEON	W/4-6 MOS ORTHO TRAINING NOT INDEPENDENT
0249	0550	OTOLARYNGOLOGIST	ORAL SURGEON	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0264	0214	THORACIC AND CARDIOVASCULAR SURGEON	GENERAL SURGEON	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0269	0214	UROLOGIST	GENERAL SURGEON	SUBS WILL NOT BE ASSIGNED INDEPENDENTLY
0305	03XX	DEPT CHAIRMAN/CHIEF OF DENTAL SERV		ANY 22XX WITH SUBSPEC ENDING IN J OR K
0305	05XX	DEPT CHAIRMAN/CHIEF OF DENTAL SERVICE		ANY 22XX WITH SUBSPEC ENDING IN J OR K
0310	03XX	ADVANCED DENTAL EDUCATION OFFICER		ANY 22XX WITH SUBSP ENDING IN J OR K
0310	05XX	ADVANCED DENTAL EDUCATION OFFICER		ANY 22XX WITH SUBSPEC ENDING IN J OR K
0335	03XX	DENTAL OFFICER GENERAL PRACTITIONER		ANY 22XX
0335	05XX	DENTAL OFFICER GENERAL PRACTITIONER		ANY 22XX
0340	0525	OPERATIVE DENTISTRY OFFICER	COMPREHENSIVE DENTIST	
0360	03XX	STAFF DENTAL OFFICER		APPROPRIATE 22XX W/ADMIN EXPERIENCE
0360	05XX	STAFF DENTAL OFFICER		APPROPRIATE 22XX W/ADMIN EXPERIENCE

MEDICAL PERSONNEL UNIT AUGMENTATION SYSTEM
TABLE LISTING
SUBSTITUTION NOBC/NEC TABLE

NOBC/	VALID	TITLE	SUB TITLE	COMMENTS
NEC	SUBST	=====	=====	=====
=====	=====			
0510	0335	ENDODONTIST	DENTAL GENERAL PRACTITIONER	SUBSP 1710S
0525	0335	COMPREHENSIVE DENTIST	DENTAL GENERAL PRACTITIONER	SUBSP 1725S
0545	0580	ORAL DIAGNOSTICIAN	ORAL PATHOLOGIST	
0560	0335	PERIODONTIST	DENTAL GENERAL PRACTITIONER	SUBSP 1760S
0569	0335	PROSTHODONTIST	DENTAL GENERAL PRACTITIONER	SUBSP 1769S
0800	08XX	ADMIN OFFICER, MEDICAL SERVICE		0801 - 0822 W/MED ADMIN EXP
0801	08XX	ADMIN OFFICER, DENTAL SERVICE		0800 - 0822 W/DENTAL ADMIN EXP
0808	08XX	PATIENT AFFAIRS OFFICER		0800 - 0822 W/AQD 6WC, 6WH OR PT AFF EXP
0814	0876	FOOD SERV OFFICER, MEDICAL FACILITY	DIETICIAN THERAPUTIC	W/ ADMIN EXP
0820	08XX	OPER MGMT OFFICER, MEDICAL FACILITY		0800 - 0822
0822	08XX	MEDICAL FACILITIES LIAISON OFFICER		0800 - 0822 W/MED CONSTRUCTION EXP
0845	0847	RADIATION HEALTH OFFICER	RADIATION SPECIALIST	
0861	0862	ENVIRONMENTAL HEALTH OFFICER	INDUSTRIAL HEALTH	
0862	0861	INDUSTRIAL HYGIENE OFFICER	ENVIRONMENTAL HEALTH	
0905	0915	DIR NRSNG SVC	NRSNG SVC ADMIN	
0915	0920	NRSNG SVC ADMIN	PT CARE COORD	
0920	0925	PATIENT CARE COORDINATOR	CLINICAL SPECIALIST, NURSING	
0920	0940	PATIENT CARE COORDINATOR	CHARGE NURSE	
0920	0982	PATIENT CARE COORDINATOR	NURSE EDUCATION COORDINATOR	
0925	0113	CLINICAL SPECIALIST, NURSING	PHYSICIAN'S ASSISTANT	
0932	0940	OPERATING ROOM NURSE	CHARGE NURSE	W\ EXPERIENCE
0932	0944	OPERATING ROOM NURSE	STAFF NURSE	W\ EXPERIENCE
0935	0940	OUTPATIENT CARE NURSE	CHARGE NURSE	
0935	0944	OUTPATIENT CARE NURSE	STAFF NURSE	
0935	0963	OUTPATIENT CARE NURSE	PRIMARY CARE RN	
0935	0986	OUTPATIENT CARE NURSE	NURSE INSTRUCTOR	
0940	0935	CHARGE NURSE	OUTPATIENT CARE NURSE	
0940	0944	CHARGE NURSE	STAFF NURSE	
0944	0932	STAFF NURSE	OPERATING ROOM NURSE	
0944	0935	STAFF NURSE	OUTPATIENT CARE NURSE	
0944	0940	STAFF NURSE	CHARGE NURSE	
0944	0986	STAFF NURSE	NURSE INSTRUCTOR	
0952	0118	ANESTHETIST NURSE	ANESTHESIOLOGIST	
0963	01XX	PRIMARY CARE NURSE PRACTITIONER	PHYSICIAN	ANY PHYSICIAN
0963	7542	PRIMARY CARE RN	PHYSICIAN'S ASSISTANT	
0982	0925	NRS EDUC COORD	CLIN SPEC, NRSNG	
0982	0986	NRS EDUC COORD	NRSNG INST	
0986	0925	NURSE INSTRUCTOR	CLINICAL SPECIALIST, NURSING	
0986	0982	NURSING INSTRUCTOR	NURSE EDUCATION COORDINATOR	
8405	8404	PARAMEDIC	FIELD MEDICAL SERVICE TECHNICIAN	
8406	8409	AEROSPACE MEDICINE TECHNICIAN	AEROSPACE PHYSIOLOGY TECHNICIAN	

MEDICAL PERSONNEL UNIT AUGMENTATION SYSTEM
TABLE LISTING
SUBSTITUTION NOBC/NEC TABLE

NOBC/ NEC	VALID SUBST	TITLE	SUB TITLE	COMMENTS
8407	8402	NUCLEAR MEDICINE TECHNICIAN	NUCLEAR SUB MEDICINE TECH	
8407	8416	RADIATION HEALTH TECHNICIAN	CLINICAL NUCLEAR MEDICINE TECH	
8408	8541	CARDIOPULMONARY TECHNICIAN	RESPIRATORY THERAPY TECH	
8425	0113	ADVANCED HOSPITAL CORPSMAN	PHYSICIAN'S ASSISTANT	
8425	7542	ADVANCED HOSPITAL CORPSMAN	PHYSICIAN'S ASSISTANT	
8425	8402	ADVANCED HOSPITAL CORPSMAN	NUCLEAR SUB MEDICINE TECHNICIAN	
8445	8483	ADVANCED OCULAR TECHNICIAN	OPERATING ROOM TECHNICIAN	W/OJT EXPERIENCE
8446	8483	OTOLARYNGOLOGY TECH	OPERATING ROOM TECHNICIAN	W/OJT EXP
8451	8452	BASIC X-RAY TECHNICIAN	ADVANCED X-RAY TECHNICIAN	
8452	8451	ADVANCED X-RAY TECHNICIAN	X-RAY TECHNICIAN	IF OJT EXP IN ADV X-RAY
8472	0000	MEDICAL PHOTOGRAPHY TECHNICIAN	GENERAL SERVICE TECHNICIAN	W/ PHOTOGRAPHIC EXPERTISE
8477	8478	BASIC BIOMED EQUIPMENT REPAIR TECH	ADV BIOMEDICAL EQUIPMENT TECH	
8483	8433	OPERATING ROOM TECHNICIAN	TRANSPLANTATION TECHNICIAN	
8483	8445	OPERATING ROOM TECHNICIAN	OCULAR TECHNICIAN	
8483	8446	OPERATING ROOM TECHNICIAN	OTOLARYNGOLOGY TECHNICIAN	
8483	8486	OPERATING ROOM TECHNICIAN	UROLOGY TECHNICIAN	
8489	0000	ORTHOPEDIC CAST ROOM TECHNICIAN	GENERAL SERVICE TECHNICIAN	W/ OJT EXPERIENCE
8489	8466	ORTHOPEDIC CAST ROOM TECHNICIAN	PHYSICAL THERAPY TECHNICIAN	
8501	8506	BASIC LABORATORY TECHNICIAN	ADVANCED LABORATORY TECHNICAIN	
8541	8408	INHALATION THERAPY TECHNICIAN	CARDIOPULMONARY TECHNICIAN	
8705	0000	DENTAL HYGIENE TECHNICIAN	GENERAL DENTAL TECHNICIAN	MUST BE DT
8752	8753	BASIC DENTAL LABORATORY TECHNICIAN	DENTAL LAB TECHNICIAN, ADVANCED	
8753	8765	DT LAB TECH, ADV	DT LAB TECH, MAXIOFACIAL	

operational unit deficiencies, it is essential that shortfalls and substitutions be evenly distributed over all receiving commands. Subspecialty substitution is authorized only in those cases when the numbers of individuals with the required specialty cannot be provided. Except as noted in Table 8-1, substitutions can be made at the local level.

5. Planning Assumptions

a. MPUAS is managed by BUMED, and executed in response to taskings from CNO in coordination with OP-093.

b. Personnel accounting is accomplished by the Commander, Naval Military Personnel Command (NMPC) for officer personnel, and the Commanding Officer, Enlisted Personnel Management Center (EPMAC) for enlisted personnel.

c. All active duty personnel are drawn from CONUS medical and dental activities.

d. At mobilization, the Mobile Medical Augmentation Readiness Team (MMART) program is disestablished and these personnel assume their designated MPUAS assignment.

e. Preventive Medicine/Occupational Health Teams will remain intact as tasked-organized units under unit augmentation and do not dissolve. NAVENVIRHLTHCEN will continue to manage those teams and deploy as directed by BUMED.

f. The status of deployed MMARTs will be handled on an individual basis with a joint decision being made between BUMED - 27 and the command currently hosting the MMART.

6. Chief, BUMED Responsibilities

a. Directs, coordinates, and monitors the alert notices and execution of MPUAS for operations.

b. Monitors and fills operational and fleet support unit active duty augmentation requirements as established in MPUAS.

c. Monitors the operational medical augmentation requirements of each augmentation receiving unit by designator and specialty. Correlates augmentation receiving unit requirements with augmentation source unit resources and tasks Healthcare Support Offices (HSOs) to coordinate the requirements.

d. Maintains assignment through HSOs and monitors their sourcing of unfilled billets with residuals.

e. Task HSOs to submit readiness reports.

f. Coordinates the maintenance and execution of the MPUAS with NMPC and EPMAC.

g. Budgets for execution of readiness training consistent with CNO direction and ensures availability of required training courses. Provides adequate funding for training facility support, curriculum development, and personnel per diem/travel.

h. Consolidates the readiness reports submitted by HSOs to determine the overall state of readiness of MPUAS and submit to higher authority as directed.

i. Identifies and incorporates Navy Active Duty Delay for Specialists officers and full time outservice training medical officers into MPUAS to the extent permitted by existing directives and policies.

j. Coordinates the detailing of command staff personnel for T-AH, fleet hospital, and RDMF. Command staff billets are Commanding Officer, Executive Officer, Director/Chief of Clinical Services, and Master Chief Petty Officer of the Command.

7. Naval Health Sciences Education and Training Command Responsibilities

a. Coordinates and provides readiness training as required for all medical and nonmedical personnel with unit augmentation assignments.

b. Budgets for MPUAS personnel training requirements consistent with BUMED directives.

c. Develops and maintains Standard Personnel Management System (SPMS) templates for MPUAS training.

d. Maintains close coordination with BUMED in the development and execution of readiness training programs.

8. Healthcare Support Offices (HSOs) Responsibilities

a. Coordinates assignment of CONUS MTF and DTF personnel to MPUAS receiving units.

b. Monitors the capability of CONUS MTFs and DTFs to continue meeting personnel requirements of receiving units and to identify shortfalls on any platforms which can be filled from residual personnel.

c. Uses SPMS to maintain current listings of personnel assigned to CONUS MTF and DTFs. Identifies them as MPUAS assignees, residuals and nondeployables.

d. Uses the SPMS to maintain current augmentation receiving unit sourcing lists and names of individuals assigned to each billet. Monitors readiness status and gender of augmentees.

e. Monitors training status of individuals assigned.

f. Uses the SPMS to consolidate CONUS MTFs and DTFs input and export data to reach BUMED not later than 20 working days after the beginning of each quarter.

g. Reviews the MPUAS standard operating procedures (SOP) for CONUS MTFs and DTFs and advises them accordingly.

h. Performs annual readiness reviews of, and assist visits to, CONUS MTFs and DTFs to verify MPUAS readiness posture and overall program conformity.

i. Maintains an HSO data base using the SPMS to manage the MPUAS program.

9. CONUS Medical/Dental Treatment Facility Responsibilities

a. Assigns and notifies qualified individuals of their mobilization assignment.

b. Brings each member to C-1 training status as defined in Status of Readiness and Training System (SORTS).

c. Maintains a command data base which will satisfy all information requirements necessary to manage the MPUAS program.

d. Budgets for and executes readiness training consistent with BUMED direction.

e. Submits readiness reports using SPMS to the HSO.

f. Develops a detailed SOP manual which specifies the protocol required for all phases of unit augmentation.

g. Establishes a mechanism for entry and exit interview with all command personnel executing PCS orders to enter them into data base, review their record for MPUAS assignment information, initiate the readiness checklist process or remove them from MPUAS assignment.

h. Establishes a hard-copy or a computer-based record on each MPUAS assignee. This file will be maintained by the POMI Officer and a hard copy should be mailed to the augmentee's next command upon execution of PCS orders.

i. Assigns personnel to BUMED-directed training and provide training programs to improve combat casualty care skills.

j. Implements the subspecialty substitution criteria through the assignment of those individuals with the greatest capabilities in the required skills.

k. Identifies all personnel assigned as substitute specialists/technicians and train them in their contingency role.

l. Budgets for, purchases and administers camouflage uniform requirements to meet guidelines of FMF training.

10. OCONUS MTF and DTF Responsibilities

a. Maintains current MPA which accurately reflects augmentation requirements for full expansion capability (M+1).

b. Develops SOPs for the reception, transportation, berthing, orientation and assimilation of augmentation personnel coming from CONUS-based sourcing units.

CHAPTER 9

PREPARATION OF PERSONNEL FOR AUGMENTATION

1. Introduction. This chapter is applicable to the active and reserve components. Commanders will certify in writing that all personnel are movement qualified before beginning individual or unit deployments. Commander certification will be accomplished by local procedures.

2. References

- a. BUMEDINST 6440.5
- b. MANMED, Chapter 15
- c. BUMEDINST 6150.1
- d. BUMEDINST 6230.3
- e. BUMEDINST 6810.1
- f. OPNAVINST 1740.4
- g. Naval Military Personnel Manual 15560A
- h. SECNAVINST 5300.30C
- i. OPNAVINST 5510.1H

3. The following minimum standards will be met before individual or unit deployment (peacetime and mobilization):

a. Medical. All deploying personnel will be physically qualified for duty with the Operating Forces, including Dental Class 1 or 2 per reference b.

(1) HIV screening is required before departure from CONUS. Active and Reserve personnel scheduled for OCONUS PCS or deployment that will exceed 180 days must have been tested within 6 months before date of departure. Personnel scheduled for deployment or exercises that will not exceed 180 days OCONUS must have been tested within 24 months before departure.

(2) Personnel will be screened and given immunizations as required before deployment.

(3) Members requiring spectacles (includes contact lens wearers) must have two pair of spectacles, or contact lens and one pair of spectacles, and have gas mask inserts.

(4) Medical warning tag will be issued as required.

b. Dental. All personnel will have a dental record and an identification panographic radiograph on file at the DoD-operated central panograph storage facility. Reserve personnel must complete the duplicate requirement as soon as possible.

(1) Personnel are not deployable to CONUS or OCONUS for any exercise, PCS, TDY, ADSW, or ADT unless a dental record is available for identification purposes.

(2) Where personnel process through active duty facilities, the duplicate panograph will be processed before movement within CONUS or OCONUS.

(3) If deployment is required before a dental record can be completed, one or more of the following documents, filed as a dental record, will serve as an interim substitute until the above requirements can be met: SF 603 with section I, part 4, and section II completed or bitewing radiographs or full mouth radiographs, properly identified.

(4) The original dental record, including the original panograph, will remain with the appropriate CONUS dental record custodian and will not be deployed with the unit while in TDY status.

c. Other documents required:

(1) Identification card (DD Form 2N) must be current and must be carried at all times, including travel to or through terrorist areas.

(2) Identification tags. Personnel will wear two ID tags around the neck, with metal necklaces when traveling on government business or engaged in field training.

(3) DD Form 93 (Record of Emergency Data).

(4) VA Form 29-8286 (SGLI Election).

(5) Passports for those countries that require them.

d. Family Care Counseling and Planning. Pregnant women, in-service couples with dependent family members, and single parents will be counselled by commanders. The commander may designate this function to a responsible individual in writing.

e. A personal affairs briefing by an attorney will include information concerning the use and advisability of wills and powers of attorney. In deployments and emergency situations, the documents may be prepared immediately. In other circumstances, arrangements will be made to ensure that necessary documents are prepared for those individuals who need them. The briefing should include the option of executing allotments and pay options.

f. Security Clearance. Enlisted personnel requiring security clearances will not move until centralized assignment procedure requirements are met (CONUS to OCONUS).

4. Reference (a) of this chapter contains a sample unit augmentation personnel readiness checklist.

CHAPTER 10

RESERVE COMPONENTS OF THE NAVY

1. Mission. The Naval Selected Reserve Program is designed to provide trained and equipped units and qualified individual personnel to rapidly expand the Navy in time of crises. These units are considered available immediately and are ready for transportation to their gaining command 72 hours after issuance of the mobilization/call-up order. The Individual Ready Reserve (IRR), Standby Reserve and Retired Reserve are available to fill mobilization requirements at varying times beyond M-day.

2. References

a. SECNAVINST 1300.13, Naval Personnel Augmentation of the Fleet Marine Force (NOTAL)

b. NAVPERS 15560, Naval Military Personnel Manual, Articles 1880240-1880250 (NOTAL)

c. DODDIR 1235.10, Mobilization of the Standby Reserve

3. Reserve Mobilization/Call-up Resources. The Naval Selected Reserve will increase the Navy's combat capability upon mobilization/call-up by delivering trained, combat-ready resources, commissioned units, reinforcing units, sustaining units and individual mobilization augmentees.

a. Commissioned units are command units with organic equipment such as aircraft squadrons, ships, construction battalions, and the Reserve Command operational staffs which function as the Immediate Superior in Command (ISIC) for the commissioned Reserve Command units. They shall be commanded by regular or reserve officers and manned with an appropriate mix of active duty (Training Active Reservist (TAR) and USN) and Selected Reserve personnel. The active duty personnel shall be an integral part of the unit for continuity and training. These commissioned units are tasked to deliver a complete operational entity to the fleet when required.

b. Reinforcing units are Naval Reserve units which provide trained Selected Reserve personnel to active force ships, aircraft squadrons, staffs, shore based commands and some Marine Corps combat commands which are not manned during peacetime at required wartime levels. The requirements for these Selected Reserve personnel are an output of the Navy's Manpower Mobilization System (NAMMOS), ships manning documents (SMD), and squadron manning documents (SQMD).

c. Sustaining units augment fleet and force support activities with the trained personnel necessary for a surge capability and for sustaining the high level of activity required to support deployed forces.

d. Individual Mobilization Augmentees (IMAs) are individual Selected Reservists who are also required to meet specified NAMMOS requirements but who do not require the unit training associated with reinforcing units described above.

4. Naval Reserve Personnel Center (NRPC). Upon receipt of CNO direction, NMPC and BUMED (with EPMAC assistance) will initiate action to reassign active-duty support for augmenting fleet, overseas installations, and Fleet Marine Force (FMF). Reserve units will be identified by CNO for mobilization based on CINC requirements and program sponsor recommendations, and the contingency scenario. Designated Selected Reserve units and personnel will be specified in CNO implementing directives, which will be promulgated by message to NMPC, Commander, Naval Reserve Force (COMNAVRESFOR), and NRPC. Upon receipt of the CNO directive, COMNAVRESFOR and NRPC will implement and coordinate mobilization/call-up of units and individuals.

5. Mobilization/Call-up Authority and Planning Guidance. For the Navy to meet the different types of mobilization or call-up, the following guidance is provided:

a. Presidential Selected Reserve Call-up Authority:

(1) The Presidential Selected Reserve Call-up (200K) is authorized when the President determines that it is necessary to augment the active forces for any operational mission. A total of 200,000 Selected Reservists can be called from all services. Length of recall is limited to 90 days, with one 90-day extension if certified by Congress to be necessary by the President. The authority does not allow recall of IRR.

(2) The fleet CINCs and CINCUSNAVEUR list those units required for recall in the pre-conflict portion of their OPLANS. If there is no OPLAN for a particular contingency, the CINC must notify CNO (OP-601) of the requirement by message, listing the Reserve Unit Identification Code (RUIC) and the Active Unit Identification Code (AUIC) of the units to call-up. The call-up of other Selected Reserve units, required to support personnel and/or missions of those initially recalled, must be directed by CNO and identified by RUIC and gaining command AUIC.

b. Partial mobilization allows mobilizing up to one million combined Reserve Components of the Armed Forces. In contingencies where an OPLAN has been prepared, the Naval Reserve Forces identified in the Time-Phased Force Deployment List (TPFDL) may be the initial Naval Reserve mobilization requirement. If there is a no OPLAN contingency or where additional requirements are identified, CNO (OP-601) must be notified as stated in paragraph 5a(2). The IRR can be used in partial mobilization and may be used to backfill the Selected Reserve or active units on a priority basis.

c. Full mobilization expands the active Armed Forces as a result of action by Congress or the President to mobilize all units in the existing approved force structure. Full mobilization makes all Selected Reserve units, IRR, Standby, Fleet Reserve and retired personnel available for recall.

d. Total mobilization expands the active Armed Forces as a result of action by Congress and the President to organize and/or generate additional units or personnel beyond the approved existing force structure, and the resources needed for their support, to meet the total requirements of a war or other national emergency involving an external threat to the national security.

e. Figure 10-1, the Mobilization Spectrum/Call-up, provides a summary of the authority for each phase of mobilization.

6. Command Responsibilities. Subordinate commands are to:

a. Identify and plan for Selected Reserve personnel assigned to their command.

b. Develop standard operating procedures (SOP) for processing reservists reporting for active duty.

c. Determine impact on command of large number of reservist reporting for active duty (berthing, messing, training, impact on the facility, administrative support, transportation requirements, etc.)

d. Maintain computerized manpower lists by NOBC< NEC, of those mobilized and backfill needs.

Figure 10-1

Authority to Order Mobilization

Situation	Action Required	Authority	Personnel Involved	Remarks
1. Any level of emergency.	Publish order to active duty.	10 USC 672 (d) 10 USC 688 (a)	Volunteers from National Guard and Reserves. Retired members of the Regular forces and Reserve retirees with 20 years of active duty.	May be used for any lawful purpose. Consent of the Governor is required for NGB members serving under 10 USC 672 (d).
2. Domestic emergency (selective mobilization).	Presidential proclamation to disperse under 10 USC 334 and executive order under 10 USC appropriate to purpose of the call.	10 USC 3500, 8500 and appropriate orders of higher authority (10 USC 331, 332, 333).	National Guard and active forces.	May be used for: Federal aid to States in case of insurrection (10 USC 331); Enforce Federal authority (10 USC 332); Suppress interference with State and Federal law (10 USC 333).
3. Operational mission requiring augmentation of active force (200K Call-up).	Presidential executive order.	10 USC 673b PL 96-584	Units and individuals of Selected Reserve; limited to 200,000 (all Services) for up to 90 days (may be extended for an additional 90 days).	President must report to Congress within 24-hours on circumstances and anticipated use of forces; may not be used in lieu of a call-up (10 USC 331, 3500, and 8500) or for disaster relief.
4. Contingency operation, war plan, national emergency (partial mobilization)	Presidential proclamation of a national emergency and an executive order.	10 USC 673 (a)	Ready Reserve units, Individual Ready Reserve, and Retirees; limited to 1 million (all Services) for up to 2 years.	President may extend appointments, enlistments and periods of service when Congress is not in session (10 USC 671 (b)).
5. War or national emergency (partial, full, or total mobilization).	Passage of a public law or joint resolution by the Congress declaring war or national emergency.	10 USC 671 (a) 10 USC 672	Ready Reserve units, Individual Ready Reserve, Standby Reserve, members of Retired Reserve; no numerical or time limitation unless established by Congress.	May extend enlistments in Regular and Reserve forces and extend period of active service for duration of the war, plus 6 months.

CHAPTER 11

CIVILIAN PERSONNEL

1. Introduction

a. This chapter provides basic information on development of Civilian Personnel Mobilization Plans (CPMP) in conjunction with command and activity mobilization plans.

b. The Navy's civilian work force is a key element in plans and efforts to build a superior maritime force. The civilian work force is essential for efficient operation in peacetime and even more during mobilization. Effective civilian mobilization planning and preparation are necessary steps to assure preparedness to mobilize and execute successful naval strategy.

c. On M-day and after, demand for civilian personnel increases building toward and sustaining full mobilization. During mobilization, new civilian positions will be created. Additional personnel will be needed to replace peacetime employees who are recalled to perform military duty or inducted into military service, and shore-based military personnel who are reassigned to sea duty. Thus, the Navy will need to acquire new personnel with a wide range of skills and occupations.

2. Reference. OPNAVINST 1000.16G.

3. Policies

a. It is Navy policy to institute vigorous, continuing civilian work force mobilization planning and management to ensure maximum readiness in response to crisis situations.

b. The top priority of the Civilian Personnel Office (CPO) during mobilization shall be to fill civilian vacancies on the wartime authorization document, including vacancies created by the call-up of military reservists, retirees and draft eligibles.

c. Plans will be complete only requiring only update and will be maintained in a ready-for execution status.

4. Civilian Personnel Planning Criteria. The Navy does not have a readily available pool of trained civilian manpower to fill its increased civilian manpower requirements after mobilization. By planning its total mobilization manpower requirements against known military and civilian personnel figures, Navy planners can balance requirements against known constraints. The following policies and assumptions apply:

a. Civilian manpower will be compensated for extended work periods. Civilians employed at naval activities at M-Day provide some of the trained cadre necessary for mobilization expansion.

b. M-Day Availability. Since the Navy will not have an immediately available pool of civilian manpower at M-Day, increased hiring may begin then. Upon mobilization, employment constraints are expected to relax. Hiring processing time will be reduced and claimants may reassign personnel as necessary.

c. Sea/shore rotation will not be an issue, and those tasks reserved for shore duty may be accomplished temporarily by civilians. There may be instances, for reasons of security or immediate fill, when tasks will be temporarily filled by military personnel only, although such jobs may have been purposely filled by civilians during peacetime.

d. Documentation. To help assess Navy's total human resource needs, civilian personnel requirements are recorded in the same format as military requirements. Mobilization requirements are recorded by time phase on the activities' manpower authorization listing (OPNAV Form 1000/2).

5. Responsibilities. All medical and dental activities must:

a. Develop a Civilian Personnel Mobilization for incorporation into all command and activity mobilization plans.

b. Ensure civilian mobilization planning is adequate to support the wartime mission of the installation/activity.

c. Establish priorities to ensure managers and the CPO have resources needed to carry out their mobilization.

d. Identify those functions that will be eliminated or drastically curtailed during an emergency.

e. Identify training needs.

f. Conduct annual review and update of wartime manning documents, standby SF52s (Request for Personnel Action), and job descriptions.

g. Review potential substitutability and backfill for functions where military personnel will deploy (e.g. move a nurse working in outpatient pediatrics to support inpatient functions.)

h. Providing civilian manpower mobilization data to the CNO (OP-01) during the annual Navy Manpower Mobilization System (NAMMOS) update.

CHAPTER 12

LOGISTICS/NAVY WAR RESERVE PROJECTS

1. Introduction. Navy War Reserve Projects (also referred to as CNO Special Projects) are established the CNO (OP-04) in support of specific contingency plans for which material may be acquired and retained.

2. References. The following references support the contents of this chapter:

- a. FMSOINST 4440.12H
- b. NAVSUP MANUAL, vol II
- c. NAVMEDCOMINST 6440.2
- d. DODDIR 6430.2
- e. OPNAVINST C3501.2H
- f. MCO 6700.2C
- g. BUMEDINST 4235.7
- h. CINCPACFLTINST 4235.2
- i. BUMEDINST 6700.13F

3. Policy and Guidance. Certain special projects approved by CNO constitute the Navy Prepositioned War Reserve Material (PWRM) program, which is set forth in the Navy Capabilities and Mobilization Plan (NCMP) and OPNAVINST 4080.11. Each project or element thereof is assigned a sponsor whose efforts are coordinated through CNO (OP-41). These references direct System Commands to take appropriate actions, within budgetary limitations, to procure and reapply assets necessary to support these projects.

4. Objectives

a. The objective of the PWRM program is to achieve and maintain the national materiel readiness required to support the operating forces by:

(1) Providing a source of selected combat-ready supplies and equipment capable of sustaining naval forces during peacetime emergencies and in the initial phases of a contingency.

(2) Achieving the capabilities to expand and repair existing overseas bases and to construct new austere bases when required under peacetime emergencies or contingencies.

b. BUMED's objectives in support of the Navy War Reserve Projects are:

(1) To achieve standardization and compatibility of material and equipment in medical and dental support systems distributed, stored, and maintained for U.S. and Allied nations' use.

(2) To improve material readiness through the refinement of materiel planning factors for medical and dental facilities.

5. Responsibilities

a. Chief, BUMED is responsible for computing Navy mobilization requirements for all medical materiel items or Class VIII in the DoD section of the Federal Supply Catalog (FSC). Requirements consist of all medical materiel in the quantities necessary to maintain and expand existing Navy medical and dental facilities on a worldwide basis.

(1) The Naval Medical Logistics Command (NMLC) is under the direction of the Chief, BUMED. In concert with medical logisticians at CNO and CMC, NMLC projects peacetime and mobilization Class VIII requirements for all Navy and Marine Corps organic medical and dental units, based upon assigned missions. NMLC manages and maintains Authorized Medical and Allowance Lists (AMALs) and Authorized Dental Allowance Lists (ADALs) for the Operating Forces; directs the initial outfitting of the units of the Operating Forces; and provides Navy input for management of the Class VIII section of the FSC (item entry, use, migration, etc.).

(2) The Fleet Materiel Support Office (FLEMATSUPPOFF or FMSO), with technical guidance from NMLC, manages the demand-based medical segment of the Navy Retail Supply System.

(3) The Defense Logistics Agency (DLA) and Defense Personnel Support Center (DPSC) are the integrated materiel managers for Class VIII items. They are responsible for meeting the supply support requirements for Class VIII which they manage centrally for the military services and other Government agencies. DPSC and DLA maintain liaison with the civilian industry; procure, store, distribute, and manage Class VIII; and coordinate industrial preparedness planning.

b. Medical/dental treatment activities are, at a minimum, responsible for the following plans and activities to support this chapter:

(1) Estimate average days of supply maintained to support both current bed capability, normal bed capacity, and expanded bed capacity.

(2) Identify total supplies and equipment requirements to support maximum facility capacity mix for 60 days (wartime casualties). Significant shortfalls (considering all available assets, whether end-use or stock-funded materiel) should be identified. Separate requirements will be identified for clinics or inactive hospitals.

(3) Identify physical storage facilities to maintain necessary expansion materiel. Efforts should be directed toward use of base nonmedical buildings of opportunity, as well as submission of MILCON requests.

(4) Determine nonmedical items (i.e., ambulances, trucks, tentage, etc.) to support the facility's role in casualty reception and care (including VA and NDMS), or support of operational units.

(5) Identify categories of supplies and equipment which are absolutely critical to the achievement of each level of operation (i.e., cadre, normal operating, expanded).

(6) Develop procedures and policies to rapidly expand to maximum capacity, including possible local sources for critical Class VIII items.

(7) Maintain ongoing liaison with area coordinator and base commanders to determine specific planning and procurement guidance for CB protective items.

(8) Endeavor to rotate shelf-life materiel as a subfunction of normal supply consumption.

c. NMLC. The following policy guidance relates to accomplishing specific responsibilities delineated in paragraph 4b.

(1) In selecting items and quantities of items for retention as PWRM, and in planning and programming procurement, careful consideration will be given to such factors as shelf life, rate of obsolescence, storage and future military utility of the item.

(2) Special attention will be given to commercial, easy-to-procure items which are currently held in authorized reserve stocks. These items should be examined frequently to eliminate those which are no longer considered an "essential item" or can be reasonably provided within the specific time frames, by placing greater reliance on supply system stocks, the nation's industrial base and commercial inventories.

(3) Upon request, provide medical activities with baseline materiel requirements necessary to maintain maximum expanded capacity for 60 days.

d. Coordination Functions. During development of plans to support this chapter, close coordination should occur with both the area coordinator and the base commanders about not only storage and movement requirements, but also transportation and other support.

6. Personnel. Personnel to support Navy War Reserve Projects are provided from active naval activities and selected Naval Reserve programs.

7. Navy War Reserve Projects. A listing and brief description of Navy War Reserve Projects is essential to accomplish complete logistics support and mobilization planning. Table 12-1 provides a list of projects, sponsors and procurement priority.

TABLE 12-1

NAVY WAR RESERVE PROJECTS, SPONSORS, AND PROCUREMENT PRIORITY

Project/Project Element	Sponsor	Priority
Fleet Hospital Element	NAVSUP	1
Blood Donor Element	BUMED	2
Surgical Teams	BUMED	3
Marine Corps Reserve Medical Support Element	BUMED	4
OWRMR - Durable Materiel	DLA	5
OWRMR - Consumable Materiel	DLA	6

8. Project Descriptions. Coordinated Navy and Marine Corps medical logistics planning is necessary at all organizational levels to ensure sustainability of naval forces, as well as the availability and effective employment of Medical Department resources. As directed by BUMED, NMLC computes the total medical and dental War Reserve Materiel Requirements (WRMR) based on guidance in the DoD Defense Planning Guidance (DPG), Navy Capabilities and Mobilization Plan (NCMP), Marine Corps Capabilities Plan (MCP), CNO planning guidance, DLA guidance, and other directives. WRMR are composed of two categories of materiel: Prepositioned War Reserve Materiel Requirements (PWRMR) and, Other War Reserve Materiel Requirements (OWRMR). War Reserve Materiel Stocks (WRMS) consist of assets to satisfy these requirements. WRMS are maintained at levels designated to meet specific requirements during periods defined in the NCMP.

a. PWRMR

(1) PWRMR is that portion of the total WRMR which is reserved and prepositioned at or near the point of planned use or issue to the user before hostilities. This action reduces reaction time and assures timely support of a specific force or project until replenishment can be effected. Assets are normally authorized for up to 60 days of operation.

(2) Navy War Reserve Projects (NAVWARP). NAVWARP's are established by CNO and constitute the Navy PWRM program. Each NAVWARP provides authorization for materiel to be acquired and retained in support of specific contingency plans. Each project or element thereof is assigned a sponsor within OPNAV. The following NAVWARPs provide essential medical support materiel to the operational commanders in the event of a national emergency, peacetime contingency, or general war:

(a) Marine Corps Reserve Medical Support per OPNAVINST 4080.11C, provides materiel support for the Fourth Marine Division/Wing Team.

(b) Medical Support

1 Surgical Teams Element provides materiel (i.e., MMART blocks) to outfit and support surgical team operations in existing facilities or vessels.

2 Blood Donor Element provides essential medical materiel for 21 days at designated blood donor centers which ensures blood donor center capability to supply the Operating Forces with blood in contingency operations and to support local, regional, and national emergencies. This materiel is held in the Naval Stock Account at designated whole blood donor centers in PWRMS. An additional 60 days of PWRMS is held at central supply points.

3 Fleet Hospital Element provides materiel necessary to support fleet hospitals.

b. OWRMR includes secondary materiel items to support U.S. Naval Forces required in support of a general war for the period D+61 through D+180 days as designated by DPG. OWRMS is not held or managed by the Navy. DLA is responsible to program and develop an industrial base from which to obtain the stock. OWRMRs are determined as follows:

(1) Individual item requirements for consumable materiel are determined by estimated wartime usage rates formulated from peacetime issue experience, professional judgement, projected population at risk, the concept of operations, projected environment, and other planning factors.

(2) Individual item requirements for durable materiel are determined by factoring the quantities included in individual activity allowance lists and the number of facilities planned for activation. Replacement of durable materiel is based on an item density using the average projected life and loss or destruction rate.

c. Materiel Inventories. Medical and dental materiel is provided on the following basis:

(1) Ships--In accordance with established allowances required to provide the level of care specified by OPNAVINST C3501.2H.

(2) Fleet Marine Forces--In accordance with established allowances to meet mission assignment. Allowances are described in MCO 6700.2C.

(3) BUMED Overseas and CONUS Shore-based Activities-- In accordance with FMSOINST 4440.12H and NAVSUP Manual, vol II, Supply Ashore.

(4) Blood Products--See Chapter 12, Navy Blood Program, of this Instruction.

(5) Mobile Medical Augmentation Readiness Teams (MMARTs) assets are maintained by the Supply Block Maintenance and Distribution Center, Marine Corps Logistics Base, Barstow, CA in accordance with NAVMEDCOMINST 6440.2 or as otherwise directed.

(6) Fleet Hospitals--In accordance with established allowances, DoDDIR 6430.2.

CHAPTER 13

NAVY BLOOD PROGRAM

1. Purpose. To provide guidance applicable to elements of the Navy Blood Program (NBP) and its integration into the Department of Defense (DoD) Armed Services Blood Program.

2. Scope. Portions of this chapter apply to all naval medical/dental treatment commands.

3. References

- a. NAVMEDCOMINST C3500.1 Series
- b. Code of Federal Regulations, Title 21, Food and Drugs, current edition
- c. NAVMED P-5120, Current Edition
- d. NAVMED P-5101, Current Edition
- e. NAVMED P-5123, Current Edition
- f. NAVSUPINST C4080.29 Series
- g. OPNAVINST 4080.11 Series

4. Command and Control

a. General. The NBP can be activated and expanded in response to local/national emergencies, within the Department of the Navy, upon request by the Armed Services Blood Program Office (ASBPO), or automatically at specific alert conditions. Table 13-1 identifies Navy Blood Donor Centers (BDC), assigns quotas, and identifies receiving Armed Services Whole Blood Processing Laboratories (ASWBPL). Table 13-2 identifies triservice staffing standards for BDC cadre personnel.

(1) Local activation. Individual commanding officers/officers in charge can initiate contingency BDC operations in response to local emergencies as required. Consumable blood donor materiel used to support such operations must come from the command.

Table 13-1

NAVY BLOOD DONOR CENTERS

CONUS BLOOD DONOR CENTER LOCATIONS

<u>FACILITY</u>	<u>DAILY UNITS QUOTA</u>	<u>DESIGNATED ASWBPL*</u>
NH BEAUFORT SC	150	II
NNMC BETHESDA MD	250	I
NH BREMERTON WA	150	II
NH CAMP LEJEUNE NC	250	I
NH CAMP PENDLETON CA	250	II
NH CHARLESTON SC	200	I
NH GREAT LAKES IL	300	I
NH GROTON CT	150	I
NH JACKSONVILLE FL	200	II
NH LONG BEACH CA	150	II
NH MILLINGTON TN	250	II
NH NEWPORT RI	150	I
NH OAKLAND CA	150	II
NH ORLANDO FL	300	I
NH PENSACOLA FL	200	II
NH PORTSMOUTH VA	250	I
NH SAN DIEGO CA	300	II

*ASWBPL I=MCGUIRE AFB
 II=LACKLAND AFB

The daily quotas are an average over an 80-day period. Commanding officers will ensure "cadre" designation for personnel to collect at least the assigned quota.

OCONUS Blood Donor Center Locations**

NH NAPLES IT
 NH ROTA SP
 NH GUAM
 NH OKINAWA JA
 NH SUBIC BAY RP
 NH YOKOSUKA JA
 NH ROOSEVELT ROADS PR

** OCONUS BDCs will establish contingency quotas.

**BLOOD DONOR CENTER (BDC)
Manpower Requirements
23 MAY 1990**

Table 13-2

UNITS COLLECTED PER DAY	NOBC/NEC BREAKDOWN REQUIREMENTS				
	0866	8506	8501	0000	TOTAL
25	1	1	1	0	3
50	1	2	2	1	6
75	1	3	2	3	9
100	1	3	3	5	12
125	1	5	4	5	15
150	1	6	5	6	18
175	1	7	6	7	21
200	1	8	6	8	23
225	1	9	7	9	26
250	1	10	8	10	29
275	1	11	9	11	32
300	1	12	10	12	35

Personnel assigned to augment BDCs must be designated by name and shall not be concurrently or collaterally assigned to any other MPUAS platform. Individuals are to receive a minimum of 8 contact hours of training each quarter. NECs, in descending order, can be substituted for a less specialized NEC. Workload (productivity) calculations were based on 68.8 CAP Units/donor; 84 hours/week/individual (7 days X 12 hrs/day); and 83.3% productivity/hour (50 min/hour). Calculations are based on 4 weeks (28 days).

Example: $\frac{68.8 \text{ workunits/donor} \times 25 \text{ donors/day} \times 28 \text{ days}}{336 \text{ hours}} = 3 \text{ personnel}$

(2) CINC activation of overseas BDCs. Cognizant Joint Blood Program Offices (JBPO) will direct the commencement of contingency operations at overseas BDCs in response to needs and in support of blood product requirements identified in applicable planning documents.

(3) BUMED activation of CONUS BDCs. BUMED directs the commencing contingency BDC operations in CONUS in response to local/national emergencies, emergencies within DoN/DoD or at the request of ASBPO.

(4) Automatic activation of CONUS BDCs. Rapidly evolving world events may preclude BUMED from activating CONUS BDCs. Automatic activation of CONUS BDCs will occur as outlined in Blood Center Alert Actions, appendix G.

b. Alternate control of CONUS BDCs. In the event BUMED cannot exercise control over CONUS BDCs, alternate control of the NBP will be assumed as outlined in the Continuity of Operations Plan (COOPLAN).

5. Concept of Operation. The transition to contingency BDC operations occurs in two phases: BDC alert, and BDC activation. The urgency may compress these phases into a single tasking order:

a. BDC Alert, Appendix G.

b. BDC Activation, Appendix I.

(1) Immediate shipment of available inventory. Available inventories are the products onhand in excess of that required to meet anticipated patient requirements. The order directing shipment will specify the products, ABO-Rh, maximum acceptable age of the products, and a shipping destination.

(2) Blood Collection/Shipment Tasking. The tasking order will also specify:

(a) The order to commence expanding blood collections.

(b) The quota of blood products for shipment by each tasked BDC.

(c) The ABO-Rh distribution of the products to be shipped.

(d) The frequency of blood shipments.

(e) The blood product shipping destination.

(f) The latest arrival time at the destination for the first shipment.

6. Response to Tasking. When directed, tasked BDCs will begin collecting, processing and shipping blood products. All products will be collected and processed according to references (b) through (d) of this chapter unless directed otherwise. The documentation, packing, shipping, and reporting guidelines given in reference (e) will be followed to by all tasked BDCs. Blood shipment reports (BLDSHIPREP) will comply with Appendix H. Blood shipping boxes will be packed with products of the same ABO and Rh groups, where possible.

7. Failure to Meet Assigned Quotas. All BDCs are expected to make every effort possible to meet quotas. Situations that result in, or can be projected to result in, a failure to meet assigned quotas must be reported to BUMED.

8. Blood Donor Center Staffing. Each BDC officer shall work in concert with the POMI to identify by name, personnel required to man BDC operations in support of the daily donor quota in Table 13-1. These individuals will be designated cadre, fenced from MPUAS requirements, and receive quarterly training. Due to shortages within the 8501/8506 communities, BUMED may identify cadre personnel at one command who will be trained for donor operations at another BDC. Commands who experience a shortage of 8501's shall fill cadre requirements with excess 8506's. Shortfalls shall be brought to the attention of BUMED-273.

9. Manpower Training. Parent commands, with personnel designated for augmentation of external blood program facilities and for contingency staffing of local BDCs, will provide those individuals with a minimum of 8 contact hours of training per quarter. Minimum training elements are given in detail in Table 13-3, Navy Blood Training Program. The training program will draw on the guidance contained in references (b) through (e) and local BDC standard operating procedures.

10. Contingency BDC Materiel. References (f) and (g) apply to PWRMS. NMLC monitors the status of these consumable supplies and coordinates requests for replenishment with FMSO. MTF commanding officers with Blood Element PWRMS will ensure peacetime use of PWRMS with adequate stock rotation. Using PWRMS supplies in daily peacetime operations will assist in eliminating retraining "cadre" personnel.

TABLE 13-3

NAVY BLOOD TRAINING PROGRAM

Training Elements	Training Applications*		
	HM 8506	HM 8501	HM 0000
1. Donor Operations			
a. Donor Selection	O,L	O,L	O,L
b. Arm Selection	O,L	O,L	O,L
c. Phlebotomy	O,L	O,L	O,L
d. Donor Care	O,L	O,L	O,L
e. Unit Segmenting	O,L	O,L	O,L
f. Donor Records	O,L	O,L	O,L
2. Component Preparation			
a. Unit Centrifugation	O,L	O,L	O,L
b. Red Blood	O,L	O,L	O,L
c. Single Donor Plasma	O,L	O,L	O,L
d. Platelet Concentrate	O,L	O,L	O,L
e. Component Records	O,L	O,L	O,L
3. Donor Unit Processing			
a. ABO and RH Testing	A,O,L	A,O,L	
b. Antibody Screening	O,L	O,L	
c. STS	O,L	O,L	
d. HBSAg Testing	O,L	O,L	
e. Unit Labeling	A,O,L	A,O,L	A,O,L
f. HIV/HTLV1 Testing	O,L	O,L	
g. Processing Records	O,L	O,L	
4. Shipments and Reports			
a. Packing and Documentation Containers	A,O,L	A,O,L	A,O,L
b. Administrative Shipping Procedures	A,O,L	A,O,L	A,O,L
c. Shipment Notification	A,O,L	A,O,L	A,O,L
d. Shipment Receipt Procedures	A,O,L	A,O,L	A,O,L

* Application Codes:

A=Designated ASWBPL Augmentee

O=Designated Overseas BDC Augmentee

L=Designated Local Contingency BDC Staff

Note: Officer and senior enlisted (E-7 and above) will be trained in all elements.

11. BDC Mobilization Plan (MOBPLAN). Each BDC mobilization plan must include detailed plans/actions to be taken upon activation. Once activated, each BDC must transition to contingency operations within 72 hours. Each BDC should plan on reaching maximum capability in 7 days. All blood products shipped must be fully tested unless otherwise directed. Appendix I provides a Donor Center Activation Plan Checklist. Appendix J provides a Donor Center Readiness Checklist.

12. Commanding officers with BDCs will ensure the BDC officer is an integral part of the medical mobilization planning process, involved in all command post/fleet training exercises working groups, and made available to the responsible line commander for additional duties relating to donor availability and the meeting of quotas.

13. BDC/POMI Responsibilities

a. Develop a BDC Mobilization Plan.

b. Identify and fence from MPUAS personnel required to man BDC operations in support of daily donor quota.

c. Provide quarterly training for personnel designated for blood center operations (internal and external).

d. Develop and implement a plan for rotation of Blood Element PWRMS.

e. In concert with the medical staff, develop POA&M to curtail laboratory services upon activation of blood donor center operations.

f. In concert with the medical staff, develop POA&M to curtail medical/surgical service due to loss of general service hospital corpsmen (0000s) for blood center operation support.

CHAPTER 14

RESEARCH AND DEVELOPMENT

1. Introduction. Navy research and development (R&D) is the process of fusing new concepts and technologies into operational systems to enhance Fleet combat capability and sustainability. R&D management goals are to attain maximum combat capability with a minimal expenditure of resources, and to progressively eliminate technological shortcomings before making sizeable resource commitments. To accomplish these objectives, the Navy's Research, Development, Test, and Evaluation (RDT&E) program is structured into three major components: research, development, and operational system development.

2. Responsibilities. BUMED is responsible for initiating and conducting RDT&E efforts in biological and medical sciences, behavioral and social sciences, life sciences technology, health education, health manpower productivity, and operational medical support systems in response to approved Navy and Marine Corps RDT&E requirements.

a. The Commanding Officer, Naval Medical Research and Development Command (NMRDC):

- (1) Directs and manages RDT&E programs for BUMED.
- (2) Provides advice to BUMED on matters pertaining to biological, medical, and life sciences technology.
- (3) Develops operational medical and dental support systems.
- (4) Assesses the impact of extremes of military environments on the health and effectiveness of Navy and Marine Corps personnel.
- (5) Advises designers of naval weapon systems and military equipment about: weapon systems effects on personnel, improved manpower effectiveness, criteria for life support systems, and criteria for personnel protective equipment.
- (6) Provides coordination on medical research and development among appropriate organizational units within and outside the DON.

3. Mobilization Guidance. Mobilization, commencing on M-day and encompassing a preparation for war or other emergency, includes the assembly of personnel, supplies, and materials required for active participation in operations. The role of R&D laboratories and offices includes developing materials and systems that may be completed during a period lagging M-day by a considerable time. Materials and systems under development may be urgently needed, but risks are involved in their successful completion; at the least, a delay in their application will occur.

4. R&D Mobilization Mission

a. During the earliest phases of mobilization, NMRDC will have a continuing responsibility for assigned R&D missions and functions. Mission/function changes or resource modifications applied to R&D projects will depend on a variety of factors at the time of mobilization; among these are the nature of the threat, warfare type, and the environment in the area of operations. Before or upon mobilization, each of NMRDC's R&D activities will assess the impact its facilities and projects can exert on the combat situation and the environment. An internal redirection and acceleration of projects in the more advanced categories of development must be anticipated. This is particularly true of projects that are most applicable and that can be completed in time to influence Fleet operations.

b. On mobilization, naval medical R&D programs shall be expanded, reduced or terminated as required to support the requisite level of logistic support and mobilization.

c. Emphasis will be shifted to those R&D efforts that will provide rapid development, test, acquisition and employment of combat related materials, equipment and skills. General technology based research will be limited to specific combat related problems. Multidisciplinary teams will be activated at existing R&D facilities to solve problems which may arise during the contingency mission. These teams will act as centers of expertise to assemble and maintain knowledge and relevant information in easily accessible form.

(1) Specific mission areas which the research effort will focus on include:

(a) Aviation

(b) Submarine/Undersea

- (c) Surface
- (d) Amphibious
- (e) Field Medicine
- (f) Special Warfare

(2) Specific medical problems on which effort should be concentrated to mission areas are:

- (a) Chemical Warfare Defense
- (b) Combat Casualty Care
- (c) Fleet Disease Surveillance (including infectious disease and biologic warfare)
- (d) Sustained Operations and Environmental Medicine

d. Before mobilization overseas R&D laboratories will coordinate with Environmental and Preventive Medicine Units through central epidemiological information coordination. Following mobilization, these efforts will be expanded and emphasized.

e. The CO, NMRDC, is responsible to:

(1) Develop, maintain and update a postmobilization medical RDT&E plan for approval by BUMED.

(2) Identify resources required to implement the postmobilization medical RDT&E plan.

(3) Identify active duty billets and specialties considered noncritical to postmobilization RDT&E programs. Provide such listing to BUMED as an annex or appendix to the implementing LSMP.

(4) Identify potential alternative sources for accomplishing critical mobilization-related research, development, training and evaluation programs.

CHAPTER 15

TRAINING

1. Introduction. Command training responsibilities, tasks and functions must provide for planning to fulfill mobilization manpower, personnel, and training support requirements. Mobilization will require a marked increase in the command's training effort; that increase is directly proportional to the volume and rate of introduction of new and reactivated ships, boats, aircraft, systems, weapons, equipment and personnel. Additional personnel, funds, and facilities will be required to support the increased workload. Plans to recruit trained and qualified administrators in sufficient time to meet requirements must be developed and implemented.

2. Policy. Responsibility for developing, coordinating, promulgating and executing command policies for training requirements belong to designated training support agencies. The primary mission is to provide guidance and delineate responsibilities for medical and dental training required to support mobilization.

a. Chief, BUMED is responsible for the individual and professional training of all active duty Navy Medical Department personnel.

b. The Commanding Officer, Naval Health Sciences Education and Training Command (HSETC), establishes priorities, procedures, and standards to meet education and training requirements, and manages the execution of approved programs.

c. The Commandant of the Marine Corps has overall responsibility for the administration of Field Medical Service Schools (FMSS) and for the provision of training for Navy Medical Department personnel assigned to the FMF.

d. The Commander, Naval Reserve Forces (COMNAVRESFOR) has overall responsibility for training and educating all inactive Naval Reserve medical and dental personnel.

e. The Commandant, U.S. Coast Guard, has responsibility for training general duty hospital corpsmen with the Coast Guard.

3. Planning Guidance

a. On mobilization (M-Day), training and education will contribute to combat casualty care skill enhancement and be confined to essential, short-term requirements dictated by scenario. Guidelines should be augmented by OPNAVINST 3061.1C, Sections N-111-1 through N-111-9.

b. Training courses shall be accelerated and shortened to the fullest extent to sustain available personnel to meet mobilization buildup requirements.

c. Skill shortfalls left by the active and reserve forces shall be filled by volunteer veterans, the direct procurement of related civilian skills, or Navy training of new accession civilians.

d. Nonessential, peacetime-only activities shall be disestablished at M+1 month, and those associated personnel identified as available for reassignment at M+1 to M+3 months.

e. Medical officer internship training shall continue after M-Day. Such training shall be accelerated to the fullest extent and should emphasize public health/preventive medicine, emergency medicine, and trauma management.

f. No personnel shall be programmed for military professional development education after M-Day.

g. COMNAVRESFOR will identify current inventory of medical Selected Reserves by NOBC/NEC specialty training level.

h. Personnel (except residents) attending basic specialized skill training programs shall continue such training under accelerated conditions until completion.

i. Staff expansion at training activities must reflect the time lag until additional students are available from recruit training commands and basic Hospital Corps School.

4. Mobilization Training Requirements

a. FMF--None; with the exception of FMSS five-day course for HM (0000) substitutes for HM 8404 (estimate greater than a 100 per year).

b. T-AH Hospital Ship

- (1) Fire Fighting - 2,256 total x 25%/year = 564/year
- (2) Damage Control - 2,256 total x 25%/year = 564/year
- (3) ATLS - 462 total x 20%/year = 92/year
- (4) ACLS - 462 total x 30%/year = 139/year
- (5) Shipboard Orientation (provided by MSC & T-AH's)

c. Fleet Hospital. Fleet Hospital Orientation Course:

$3,804 \times 10\%/\text{year} = 380/\text{year}$

d. Rapidly Deployable Medical Facility (RDMF) - RDMF Field Training:

$2,128 \times 25\%/\text{year} = 532/\text{year}$

5. Responsibilities. Medical and dental training commands are responsible for accomplishing the following planning initiatives in support of overall Navy mobilization objectives.

a. Provide formal combat casualty care skill training for all appropriate Medical Department personnel; other training shall be provided in aerospace, submarine, occupational and preventive medicine, as well as chemical, biological, and radiation (CBR) protection and treatment.

b. Develop guidelines and supporting material to conduct BUMED activities with the development of consistent, meaningful inservice training programs that emphasize combat casualty care skill enhancement for both primary and alternate contingency specialty roles.

c. Review and integrate, to the fullest extent, peacetime operational readiness training courses consistent with career pathways of Medical Department personnel.

d. Terminate Navy inservice and outservice residency training programs on mobilization (M-Day). Individuals attending outservice residency training shall return immediately to active service for further assignment. Individuals completing at least one-half of their training and considered qualified shall be identified as specialty trained for reassignment. All others shall be reassigned as primary care medical officers or general practice dental officers.

e. Discontinue military professional and nonessential training on M-Day. Personnel considered qualified in the specialty shall be identified for reassignment within it. All others shall be reassigned with their previous qualifications or specialty.

f. Shorten and accelerate basic and specialized training for Hospital Corps and Dental Technician personnel commencing M-Day. Training may be conducted 10-12 hours per day, 6 days per week. Skill training shall continue in the following critical NECs

unless projected inventories are adequate to satisfy manning requirements:

- 8402 SUBMARINE FORCE INDEPENDENT DUTY CORPSMAN
- 8404 MEDICAL FIELD SERVICE TECH
- 8407 RADIATION HEALTH TECH
- 8408 CARDIOPULMONARY TECHNICIAN
- 8409 AEROSPACE PHYSIOLOGY TECH
- 8425 SURFACE FORCE INDEPENDENT DUTY CORPSMAN
- 8432 PREVENTIVE MEDICINE TECH
- 8451 BASIC X-RAY TECHNICIAN
- 8452 ADVANCED X-RAY TECHNICIAN
- 8463 OPTICIAN TECHNICIAN
- 8482 PHARMACY TECHNICIAN
- 8483 OPERATING ROOM TECHNICIAN
- 8478 ADV BIOMEDICAL EQUIPMENT TECH
- 8479 BASIC BIOMEDICAL EQUIPMENT SYSTEMS TECH
- 8485 PSYCHIATRY TECHNICIAN
- 8492 SPECIAL OPERATIONS TECH
- 8493 MEDICAL DEEP SEA DIVING TECH
- 8501 LABORATORY TECHNICIAN
- 8506 MEDICAL LABORATORY TECH
- 8707 FIELD SERVICE DENTAL TECH
- 8732 DENTAL EQUIPMENT REPAIR TECH
- 8752 DENTAL LAB TACH, BASIC
- 8753 DENTAL LAB TECH, ADVANCED
- 8765 DENTAL LAB TECH, MAXILLOFACIAL

g. Develop annual projections of time-phased training capabilities for each training site for all NOBCs and NECs mobilization (6-day week, 10-12 hour day). Identify shortfalls in light of total training requirements.

h. Develop projections of time-phased requirements (i.e., manpower, materiel, facilities) necessary to expand each training site to its maximum capacity.

i. Develop projected time-phased capabilities for each training site for all NOBCs and NECs for specific schools and training programs that may be discontinued on M-Day.

j. Develop alternative courses of action to accomplish training enlisted members in the surgically-related skills. Identify minimum personnel requirements (by specialty) necessary to adequately accomplish the practical training phase.

k. Identify constraining factors not related to the education process which would adversely impact on the mobilization training mission. Identify alternative courses of action to minimize the negative impacts of these factors.

1. Identify alternative courses of action (i.e., on-the-job training, discontinuance of advanced technical courses, etc.) to meet overall wartime personnel training requirements.

CHAPTER 16

MEDICAL REGULATING

1. Introduction. Patients will normally be evacuated by air when transportation is available and conditions are suitable. Surface transportation on hospital ships or ships routed to the United States shall be used when airlift is not available. Designated surface vessels should have qualified personnel and sufficient material to provide adequate care for the patients being evacuated.

2. References

- a. BUMEDINST 6320.1E
- b. DOD Directive 5154.6
- c. JCS Pub 4-01
- d. NAVMEDCOMINST C3500.1B

3. Policy and Guidance. Medical Regulating (MEDREG) is the selective process by which casualties are directed to specific MTFs capable of providing appropriate care based upon the casualties' treatment requirements. This process is accomplished within and between each of the three subsystems of the Navy medical support system: theater of operations, overseas nontheater areas, and CONUS. This chapter will address the medical regulating responsibilities of only overseas and CONUS MTFs.

a. Background

(1) Casualties may be first regulated to an overseas MTF before movement to a designated CONUS MTF. Regulating casualties to an overseas location is normally accomplished through a theater Joint Medical Regulating Office (JMRO).

(2) Those casualties who will not return to duty within the stated evacuation policy will be further regulated to CONUS MTFs through the combined efforts of the JMRO and the CONUS-based Armed Services Medical Regulating Office (ASMRO). ASMRO is solely responsible for the MEDREG of all casualties to CONUS MTFs. (The evacuation policy is a theater commander's decision indicating the length in days of the maximum period of noneffectiveness that patients may be held within a facility).

(3) For the JMRO and ASMRO to effectively accomplish medical regulating, they must possess an accurate, ongoing real-time assessment of the specialty capabilities of each fixed Navy MTF.

b. Patient Regulating Process. Combat casualties are medically regulated by JMRO and ASMRO, using the following eight ASMRO contingency patient regulating categories:

Medicine	MM
Psychiatry	MP
Surgery	SS
Orthopedics	SO
Spinal Cord Injury	SC
Burns	SB
OB/GYN	SG
Pediatrics	MC

(1) When directed by appropriate cognizant authority (see reference (d) for conditions of implementation), CONUS MTFs possessing inpatient capability are to report the total beds available in each of the eight contingency specialty categories, as of 2400 local time using the Defense Medical Regulating Information System (DMRIS) or immediate precedence message with appropriate classification. If sent by message, the report is to be sent not later than 0200 each day. Messages are directed to ASMRO with the Alternate ASMRO and Chief, BUMED as INFO addressees. Navy CONUS MTFs, designated to receive casualties, are identified in Table 16-1. Tables 16-2 and 16-3 contain sample message reports. Overseas Navy MTFs are to submit bed availability per instructions of their respective JMROs.

(2) An initial report is submitted on activation of bed status reporting. The initial report will include both operating and available beds. Subsequent reports include only available beds unless there has been a change in the number of operating beds.

(3) Subsequent reports are required daily. Do not use bed status reports to pass ancillary information to ASMRO or the INFO addressees.

c. Terminology

(1) Operating Bed. A specified total number of beds in each MEDREG category which an inpatient facility is able to provide care for; personnel, necessary supporting services and materiel, must be readily available.

TABLE 16-1

NAVY CASUALTY RECEIVING HOSPITALS

	Naval Hospital, Beaufort, SC
	Naval Hospital, Camp Lejeune, NC
X	Naval Hospital, Portsmouth, VA
X	Naval Hospital, Charleston, SC
X	Naval Hospital, Great Lakes, IL
X	Naval Hospital, Newport, RI
X	Naval Hospital, Philadelphia, PA
X	Naval Hospital, Groton, CT
X	National Naval Medical Center, Bethesda, MD
X	Naval Hospital, Oakland, CA
	Naval Hospital, Bremerton, WA
	Naval Hospital, Oak Harbor, WA
	Naval Hospital, Lemoore, CA
	Naval Hospital, Corpus Christi, TX
X	Naval Hospital, Jacksonville, FL
X	Naval Hospital, Millington, TN
X	Naval Hospital, Orlando, FL
	Naval Hospital, Pensacola, FL
X	Naval Hospital, Camp Pendleton, CA
X	Naval Hospital, San Diego, CA
X	Naval Hospital, Long Beach, CA
	Naval Hospital, Twentynine Palms, CA
X	Participating National Disaster Medical System (NDMS) Federal Coordinating Centers

TABLE 16-2

WARTIME MEDICAL REGULATING
INITIAL BED AVAILABILITY REPORT MESSAGE FORMAT

UNCLASSIFIED

FROM: NAVHOSP XXXXX//CODE//
TO: ASMRO SCOTT AFB IL (OR JMRO AS APPROPRIATE)//CODE//
INFO: BUMED WASHINGTON DC//CODE//
CDR USAHSC FT SAM HOUSTON TX //HSOP//
COGNIZANT UNIFIED COMMANDER (IF OVERSEAS MTF)
COGNIZANT NAVY COMPONENT COMMANDER (IF OVERSEAS MTF)

SUBJ: INITIAL BED AVAIL REPORT AS OF 2400 LOCAL 01 JAN 00
MSGID/GENADMIN/NAVHOSP XXX//
REF/A/ASMRO SCOTT AFB IL/010011ZJAN00//
NARR/REF A (EXPLAIN REF)
RMKS/1. FACILITY MM MP SS SO SC SB SG MC TOTAL
NAVHOSP OPER
AVAIL
VA AVAIL
NDMS AVAIL
TOTAL AVAIL//

BT

---NOTE FOLLOWING POINTS;

- IMMEDIATE MESSAGE PRECEDENCE.
- EXERCISE KEY LINES.
- DO NOT INCLUDE THE LINES FOR VA OR NDMS UNTIL THE RESPECTIVE PROGRAM IS ACTIVATED.

TABLE 16-3

WARTIME MEDICAL REGULATING
DAILY BED STATUS (AVAILABILITY) REPORT MESSAGE FORMAT

FROM: NAVHOSP XXXXX//CODE//
TO: ASMRO SCOTT AFB IL (OR JMRO AS APPROPRIATE)//CODE//
INFO: BUMED WASHINGTON DC//27//
CDR USAHSC FT SAM HOUSTON TX //HSOP//
COGNIZANT UNIFIED COMMANDER (IF OVERSEAS MTF)
COGNIZANT NAVY COMPONENT COMMANDER (IF OVERSEAS MTF)

SUBJ: BED AVAIL REPORT AS OF 2400 LOCAL 01 JAN 00
MSGID/GENADMIN/NAVHOSP XXX//
RMKS/1. FACILITY MM MP SS SO SC SB SG MC TOTAL
NAVHOSP
VA AVAIL
NDMS AVAIL
TOTAL//

BT

Chapter 17

VETERANS ADMINISTRATION-DEPARTMENT OF DEFENSE (VA-DoD) CIVILIAN CONTINGENCY HOSPITAL SYSTEM

1. Organizational Structure. The VA-DoD Civilian Contingency Hospital System is a multihospital contingency system composed of VA, DoD, and civilian components.

a. The VA-DoD component was initiated in May 1982 with the enactment of Public Law 97-174. The law specified that the VA will serve as the primary healthcare backup system to DoD in the event of war or national emergency as declared by the President or Congress.

b. The civilian component is known as the NDMS. This component is the primary recipient of casualties from a national civil disaster and will provide healthcare backup to the VA-DoD Contingency Hospital System in the event of an overseas conventional war or national emergency.

2. VA Contingency Mission. As the legislatively mandated primary backup to the military health care system, local VA medical centers act as the initial and principal source of non-DoD support for military casualties. VA medical centers serve as: primary receiving centers, secondary support centers, installation support centers, and NDMS Federal Coordinating Centers.

a. Primary Receiving Centers. Designated areas of the United States (US) have been identified as primary receiving areas for the treatment of sick and wounded personnel returning from an overseas conventional war. Table 17-1 lists VA medical centers located in these primary receiving areas that have been designated as primary receiving centers.

b. Secondary Support Centers. Other VA medical centers have been designated as secondary support centers to accept transfers and share resources with primary receiving centers to maximize the availability of VA beds. The designation of secondary support centers is determined by VA medical districts and regions in designated primary receiving areas.

c. Installation Support Centers. VA medical facilities in the vicinity of military bases develop local contingency plans to provide health care services (inpatient and outpatient) to military forces assigned to the bases in the event of war or national emergency. Table 17-2 lists VA Base Support Areas.

d. NDMS Federal Coordinating Centers. The VA has designated certain VA medical centers to act as NDMS Federal Coordinating

TABLE 17-1

NAVY PRIMARY RECEIVING AREAS AND
ASSOCIATED NAVAL ACTIVITIES AND
VETERANS ADMINISTRATION (VA) MEDICAL CENTERS

<u>AREA</u>	<u>MILITARY CORR DINATING CENTER</u>	<u>VA MEDICAL CENTERS</u>
New Haven, CT	NH Groton, CT	West Haven, CT Newington, CT
Minneapolis, MN	NH Great Lakes, IL	Minneapolis, MN
Chicago, IL	NH Great Lakes, IL	Chicago-Lakeside, IL Chicago-Westside, IL North Chicago, IL Hines, IL Wood, IL
Philadelphia, PA	NH Philadelphia, PA	Philadelphia, PA
Pittsburgh, PA	NH Philadelphia, PA	Pittsburgh, PA
Providence, RI	NH Newport, RI	Providence, RI
Washington, DC	National Naval Medical Center, Bethesda, MD	Washington, DC
Charleston, SC	NH Charleston, SC	Charleston, SC
Norfolk, VA	NH Portsmouth, VA	Hampton, VA
Orlando, FL	NH Orlando, FL	NONE
Memphis, TN	NH Millington, TN	Memphis, TN
Oakland, CA	NH Oakland, CA	Livermore, CA
Los Angeles, CA	NH Long Beach	Los Angeles, CA* Long Beach, CA Sepulveda, CA Wadsworth, CA
	NH Camp Pendleton, CA	NONE
San Diego, CA	NH San Diego, CA	La Jolla, CA

* Outpatient Clinic

TABLE 17-2

VA BASE SUPPORT AREAS

VA Medical Center/Outpatient Clinic

Washington, DC
Philadelphia, PA
West Haven, CT
Providence, RI
North Chicago, IL
Charleston, SC
Hampton, VA
Memphis, TN
*Martinez, CA
*Seattle, WA
Livermore, CA
Long Beach, CA
San Diego, CA
Fresno, CA

* Does not have mission as primary receiving area.

Centers in selected primary receiving areas. Guidelines for the operations of NDMS Federal coordinating centers are in the National Disaster Medical System Coordinating Center Guide, March 1985 .

3. VA Liaison Officer to the Armed Services Medical Regulating Office (ASMRO). A full-time VA health systems specialist is assigned to ASMRO and performs three major functions: coordinating emergency preparedness planning, national regulating and transferring patients, and developing VA-DoD resource sharing agreements.

4. Before Declaration of National Emergency. During a period of national emergency, the Assistant Secretary of Defense (Health Affairs) (ASD/HA) would establish and maintain continuous communications and liaison with the VA Chief Medical Director. This is to develop current medical care delivery capability projections, determine possible medical care delivery deficiencies in military and VA systems, initiate plans or actions to resolve deficiencies, and refine patient discharge or transfer plans for nonactive-duty and non-service-connected VA patients.

5. Declaration of National Emergency

a. On declaration of a national emergency, SECDEF will request, in writing, that the Administrator of Veterans Affairs authorize the admitting and treating on a priority basis active duty military personnel at VA medical facilities. Concurrent with this request, a daily liaison will be established between the OASD/HA and the Office of the Chief Medical Director (CMD).

b. On receipt of SECDEF's request, the Administrator will prescribe the priorities for treating active duty military personnel in VA medical facilities. The SECDEF will be notified of this decision.

c. On receipt of the Administrator's decision on treatment priorities, the following actions occur:

(1) SECDEF will notify the military departments of the VA medical support prescribed by the Administrator. This notification will authorize military hospitals to coordinate directly with designated VA medical facilities.

(2) The Administrator or his designee will notify VA medical facilities of the medical support prescribed for treating active duty military personnel on a priority basis. This notification will authorize VA medical facilities to coordinate directly with designated military medical facilities to provide care.

(3) OASD(HA) and the CMD will be responsible for daily operations and interagency coordination. This will include designating liaison officials at OASD(HA) and CMD.

(4) The CMD will designate a senior BUMED official as a member of the Medical Mobilization and Deployment Steering Committee.

6. Operations During the National Emergency

a. The CMD and OASD(HA) will ensure the continued flow of critical information between the VA and DoD. This will include, as a minimum:

(1) Reports on the status of operating bed and manpower capabilities at military hospitals.

(2) Reports on the status of operating bed and manpower capabilities at VA medical centers.

(3) Projections on casualty workloads.

(4) Reports on availability of medical supplies.

(5) Reports on availability of patient transportation.

b. Within 30 days of the declaration of a national emergency, the Administrator of Veterans Affairs will submit a report to Congress on the allocation of facilities and personnel to provide priority hospital care, nursing home care, and medical services to Armed Forces members.

c. Liaison will be maintained by both agencies with the Federal Emergency Management Agency (FEMA), the Department of Health and Human Services, and other appropriate Government agencies.

7. Responsibilities of Navy Medical Treatment Facilities. The minimum responsibilities required of the MTFs are outlined below:

a. Develop liaison and identify key personnel in the local VA facility and other local military MTFs.

b. Develop a concept of operations to include the number of casualties which can be processed within a 24-hour period.

c. Establish military patient administration procedures to cover military patients treated in VA facilities.

d. Develop a triage system and requirements for airports and seaports for receipt of casualties.

- e. Submit bed availability reports to ASMRO.
- f. Develop patient transportation plans and requirements.
- g. Identify Navy personnel and facility support requirements.

CHAPTER 18

NATIONAL DISASTER MEDICAL SYSTEM

1. Introduction. The National Disaster Medical System (NDMS) is a joint Federal, State, and local mutual assistance system for a coordinated medical response in time of war, national emergency, or major domestic disaster. Table 18-1 list Navy MTFs designated to serve as Federal Coordinating Centers as a part of DoD's participation in this system.

2. References

- a. DoD Directive 6010.17, National Disaster Medical System (NDMS)
- b. DoD Directive 3020.36, Assignment of National Security Emergency Preparedness Responsibilities to DOD Components, November 2, 1988
- c. DoD Directive 3025.1, Use of Military Resources During Peacetime Civil Emergencies Within the United States, Its Territories, and Possessions, May 23, 1980
- d. Public Law 97-174, Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, May 4, 1982
- e. The National Disaster Medical System Coordinating Center Guide (March 1986), NDMS, Room 18-74 Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857
- f. The Disaster Medical Assistance Team Organization Guide (July 1986), NDMS, Room 18-74 Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857
- g. National Disaster Medical System Disaster Exercise Guide (October 1988), NDMS, Room 18-74 Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857

3. Policy. It is DoD policy that:

a. NDMS shall respond to the healthcare requirements of major mass casualty incidents resulting from a catastrophic disaster within the U.S. or a conventional military conflict involving US Armed Forces.

b. The NDMS is activated by the OASD(HA) for support of military contingencies when casualties exceed the combined capabilities of VA-DoD Contingency Hospital System.

Table 18-1

Navy MTFs Designated as Federal Coordinating Centers (FCC)

NH Groton, CT

NH Newport, RI

NH Great Lakes, IL

NH Philadelphia, PA

National Naval Medical Center, Bethesda, MD

NH Portsmouth, VA

NH Charleston, SC

NH Millington, TN

NH Orlando, FL

NH Oakland, CA

NH Camp Pendleton, CA

NH Long Beach, CA

NH San Diego, CA

c. The NDMS may be activated by the FEMA or the Assistant Secretary of Health, Department of Health and Human Services (DHHS) in response to a U.S. domestic disaster. DoD components will participate in relief operations to the extent compatible with US national security.

4. Concept of Operation--Military Contingency

a. When casualty levels exceed the capability of DoD and VA medical facilities, the system will be activated on direction from ASD (HA) through the military departments. Military MTFs will be directed to report civilian hospital capabilities to ASMRO in daily bed availability reports via the Defense Medical Regulating Information System (DMRIS).

b. On receipt of regulating information from ASMRO, the coordinating military activity will notify the civilian hospitals concerned of the pending arrival of casualties.

c. Once casualties are distributed and regulated into an NDMS area, they will be further regulated locally under the direction of the local Navy Federal Corrdinating Center (FCC).

5. Concept of Operation - Domestic Disaster

a. Navy FCCs will be activated by direction from the CNO in response to a domestic disaster. Navy FCCs will report civilian hospital capabilities to ASMRO in daily bed availability reports via the DMRIS.

b. On receipt of regulating information from ASMRO, civilian hospitals will be notified by the Navy FCC of pending arrival of casualties.

c. Once casualties are distributed and regulated into an NDMS area, they will be further regulated locally under the direction of the local Navy FCC.

6. Responsibilities

a. The OASD(HA):

(1) Coordinates DoD NDMS functions with other federal civilian agencies and the military departments.

(2) Provides NDMS policy and planning guidance to the appropriate DoD components.

(3) Ensures the military departments implement and manage assigned NDMS responsibilities.

(4) Establishes and oversees an NDMS claims processing system.

(5) Maintains liaison with the American Red Cross, the American Hospital Association, the American Medical Association, the National Association of State Emergency Medical System Directors, and other emergency preparedness organizations.

(6) Activates the NDMS in time of war or national emergency when DoD and VA bed capacity is insufficient to provide for casualties returning from an overseas combat theater.

(7) Monitors implementation, testing, and operation of the NDMS by developing and maintaining an automated capability to monitor organization, facility, and personnel participation, as well as patient distribution and administration through the Defense Medical System Support Center.

b. The Secretaries of the military departments:

(1) Issue department directives covering NDMS activities, in accordance with the policies of the Office of the Secretary of Defense.

(2) Operate and manage assigned NDMS responsibilities.

(3) Program and budget for assigned NDMS responsibilities.

(4) Establish and maintain military patient administration teams to provide personnel, financial, and medical record support for military patients in VA, civilian, and military hospitals.

c. The Secretary of the Army serves as the DoD Executive Agent for military support of civilian disaster relief to ensure DoD planning and responses include military health care commitments to the NDMS.

d. The Director, ASMRO:

(1) Serves as the medical regulating agency for the NDMS.

(2) Supports the planning, testing, and operation of the NDMS.

e. The U.S. Transportation Command:

(1) Coordinates patient movement for the NDMS through its transportation component commands: the Military Airlift Command, Military Sealift Command, and Military Traffic Management Command.

(2) Coordinates planning to meet the transportation requirements of the supported CINCs and other agencies.

(3) Coordinates with the Department of Transportation for movement of medical supplies and equipment following peacetime disasters.

(4) Supports planning, testing, and operation of NDMS.

f. The Defense Logistics Agency:

(1) Assists in identifying and providing excess and surplus military equipment and other materiel to the DoD Executive Agent for use by civilian elements of the NDMS.

(2) Coordinates the procurement and acquisition or provides from existing inventory consumable military medical supplies, equipment, and other items needed for the medical response to a domestic disaster.

7. Chief, Bureau of Medicine and Surgery. BUMED-27 is the responsible Navy medical agent in CONUS for planning, testing, and implementing provisions of NDMS to comply with guidance from ASD(HA) and Director of Navy Medicine/Surgeon General, OP-93. BUMED will:

a. Direct implementing and executing medical policy guidance for DON medical support to the NDMS and rendering assistance to civil authorities.

b. Designate specific DON MTFs as Federal Coordinating Centers in support of the NDMS.

c. Direct local participation of naval MTFs in the program with local NDMS, VA and other Federal medical facilities in the area.

d. Provide oversight coordination to establish of Military Patient Administration Teams (MPAT) for support of military casualties hospitalized in a VA or non federal facility.

e. Ensure that all DON MTFs coordinate all NDMS tasking and planning efforts with the designated echelon II and responsible line commanders before implementation.

8. Designated Navy NDMS FCCs Will:

a. Develop a NDMS operations plan which identifies agreed on responsibilities and notification measures for activating the system within the designated area of local military, VA, and civilian organizations.

b. Coordinate and execute cooperative agreements for civilian health care organizations participation in the NDMS.

c. Develop and maintain plans for the management of NDMS patients transferred into the area, ensuring the following is addressed:

(1) Receive, sort, provide emergency care, track, distribute and transport patients from the scene to area hospitals.

(2) Develop and maintain a patient locator system for patients entered into the NDMS.

(3) Develop Military Patient Administration Team (MPAT) procedures for administrative support for military casualties hospitalized in VA or non-Federal facilities.

(4) Gather and submit required bed availability reports for Federal and non-Federal NDMS participants to ASMRO.

(5) Develop and form a sustainable civilian patient reception capability sufficient for extended patient reception operations.

d. Initiate, establish and maintain memoranda of understanding (MOUs) with local hospitals for their participation in the NDMS program.

e. Maintain liaison activities with state, county and community offices of emergency services, officials, hospital executives and professional staff, and other healthcare/emergency management agencies including Emergency Medical Systems, as appropriate, for the preparing, maintaining, testing and executing area operations/reception plans.

f. Prepare, coordinate and implement at least one annual NDMS area exercise to test and critique the metropolitan area plan.

g. Formulate, justify and submit NDMS resource requirements through the existing MTF budget process. Verify annually, minimum and maximum bed figures with each NDMS participating hospitals.

CHAPTER 19

MOBILIZATION SCENARIO EXERCISE

The scenario and situations depicted herein are intended for the planners' use only. They do not portray the actual intentions of the United States in reaction to world situations. The hypothetical scenario is intended only as a means to focus the planner in the mobilization process as it might occur. This section of the LSMP is designed as a tutorial document to assist the reader in understanding the mobilization process. The goal is to provide a meaningful environment with sufficient background information to enable the planner to effectively prepare his command for mobilization.

1. Situation 1: Planning and Preparation

2. Scenario

a. As we moved into the latter part of the 1980's, world tensions and various conflicts kept the United States in an increased state of preparedness. The situation in many of the world hot spots during 1988 and the first months of 1989 continued to be of grave concern to the United States and its allies. In some areas US civilian and military personnel were subject to harassment and life threatening situations. Fighting between numerous combatants in various locations throughout the world showed no signs of ending and, in fact, had escalated during the middle of the year. US interests in certain oil-producing regions were threatened with the possible cutoff of oil. As a result, the potential for a direct armed confrontation between the United States and unfriendly governments had increased markedly over the past several months.

b. To counter this threat, US naval forces were sent to several areas to ensure that international waterways remained open. The resulting tensions threatened to turn into regional conflicts with the possible loss of access to oil supplies by the United States and its European and Asian allies. Diplomatic efforts to resolve the various situations were unsuccessful. Attempts to diffuse one situation in particular, during emergency meetings of the United Nations, were blocked. This situation continued to deteriorate, and the concern of most US leaders was that further US involvement was inevitable.

c. During this time, the Communists were faced with several internal circumstances, which caused considerable difficulty for the senior Communist party leaders. The unrest in one country was demonstrated by continued economic problems and dealings with union sponsored strikes. Unrest in two other areas also caused concern. The diverse backgrounds of two groups that populated one region continued to cause dissension. The resurgence of national pride and

the demand for more local government control in another region added to the concerns facing the party leadership.

d. These situations led to uncertainty in the Communist sphere of influence and caused concern within the US intelligence community.

e. The President, at a meeting with the Cabinet, reviewed the world situation and expressed concern that events in specific hot spots could escalate into a serious confrontation between the superpowers. He was also concerned about the situation on the European continent and the potential for renewed confrontation between East and West. He told the Cabinet that, while he did not want to alarm the American people unnecessarily, steps had to be taken immediately to increase the defense readiness of the nation. The Joint Chiefs of Staff (JCS) reviewed the defense readiness condition (DEFCON) status of the commanders in chief (CINCs).

3. Situation Lead

a. The Chief of Naval Operations in response to the Secretary of Defense, requested commanders of all major commands to provide an overall assessment of their readiness and make recommendations for increasing readiness, short of mobilization. The Navy Surgeon General directed subordinate commanders to review and evaluate the emergency procedures, policy guidance, missions, and assumptions in relation to their mobilization requirements.

b. The strength of BUMED's readiness posture is its ability to quickly transfer critical personnel resources to the deployment force and align itself to commence treating patients from a theater of operations and the mobilizing force.

4. Situation Questions and Topics

a. What documents are used as the primary source of guidance for Navy mobilization planning? Which documents are available at your Command?

b. Conduct an evaluation of the current policy guidance and determine the relevance and effect on your concept of operations.

c. Summarize the major mobilization and deployment missions for:

(1) Your individual medical/dental facility?

(2) Your installation, supported Federal semiactive installation; and State-operated mobilization station?

d. Identify major differences and/or conflicts in question 4c.

e. Adjustments to your mission must be approved at different levels in the chain of command.

(1) Who approves the type of health care missions for your command?

(2) Who approves curtailment of services on a temporary or permanent basis for inpatient and outpatient care?

(3) What are other specified or implied tasks associated with your installation and individual mission that are directed by commands or organizations other than BUMED? Develop a list of these tasks and associated missions.

SITUATION 2: INCREASED MOBILIZATION PREPAREDNESS

1. Scenario

a. During the ensuing months, tensions remained high. Various countries claimed that the United States was preparing to interfere in one oil rich region in matters purely internal to the countries of the area. They also claimed that the United States was using the situation as a pretext to impose US policy in the area.

b. Fighting between various adversaries in the region continued, with air, sea, and ground attacks taking a large toll on both civilian and military personnel of several countries. Neutral countries, and others in the region friendly to the United States, were subject to acts of terrorism and sabotage. Recently, neutral ships had been attacked in various ports and in international waters.

2. Situation Update

a. BUMED, in conjunction with the other major commands, began to take measures anticipating an early decision by the President to deploy combat forces. As a first priority they recognized a critical need, if and when deployments were initiated, to meet movement schedule dates under operation plans (OPLANS) likely to be executed. In this regard, they reviewed the responsibilities of agencies involved to ensure all procedures, coordination, and transportation requirements were clearly understood.

b. One of BUMED's first responses is to provide medical augmentation to forward deployed and deploying platforms. To meet this tasking, BUMED has apportioned augmentation requirements to its subordinate Medical and Dental Activities. As a medical planner using MPUAS, you should be familiar with the system and the policies and procedures that guide its implementation.

(1) What are the sources of guidance and taskings that provide the basis for the MPUAS?

(2) Determine what your responsibilities are to ensure MPUAS personnel assigned to your activity are prepared for deployment. What responsibilities have you delegated to specific members of your staff? How are these responsibilities carried out?

(3) Describe your procedures for alerting and recalling MPUAS personnel.

c. Designated MPUAS personnel are required to receive adequate training in their designated mobilization platform. Discuss the following.

(1) How many of your MPUAS personnel have received the required training?

(2) How many MPUAS personnel trained with a deployable unit other than the one they are designed to fill?

(3) What is the average number of days spent by MPUAS personnel in training with a deployable unit?

(4) What problems have you encountered in fulfilling this requirement?

d. How many of your MPUAS personnel are trained for survivability in a hostile environment. Describe your organization's procedures to accomplish this type of training? Identify problems and possible solutions.

e. What coordination has been made with the installation transportation officer to ensure that MPUAS personnel will be moved to their designated MTOE units within CONUS and aerial ports of embarkation (POE)?

(1) Is your installation transportation officer capable of providing the required transportation within the stated time frames?

(2) Who notifies the installation transportation officer of the transportation requirements and what authority will be used to authorize actual movement?

f. Describe experiences your MPUAS personnel have had in deploying to support a contingency operation, exercise and/or an emergency deployment readiness exercise. What were the lessons learned, and have you instituted changes to better support the program?

SITUATION 3: INITIAL DEPLOYMENT AND RESIDUAL CAPABILITY

1. Scenario

a. With the situation becoming more explosive, the Communists suddenly announced a large-scale military exercise along their southern borders. Under the guise of the exercise, they mobilized a portion of their reserve units. Intelligence sources reported conflicting views as to why these reserve units were activated. Some thought it was purely an internal response to halt the demonstrations and control the unrest in the regions. Others were convinced it was a prelude to Communist intervention beyond their borders. US intelligence sources warned of imminent hostilities in the region and provided strong evidence that the Communists were preparing to intervene. In the face of these grave developments, one friendly country requested that the United States provide military forces, citing the threat to its sovereignty. The most likely and vulnerable targets within that nation and its neighboring moderate states were the oil fields and facilities so crucial to the free world.

b. Events in Europe compounded the situation. The unrest in the north was having a profoundly disquieting effect on the Communists. Economic reform measures, which included the imposition of price hikes caused a series of strikes. Violent demonstrations protesting shortages and high prices occurred in several seaports and mining areas. Open criticism of the government was rampant. It was apparent that the discontent was reaching a crisis level.

c. If the unrest continued, it could cause difficulties for the ruling Communist leadership. If the local governments could not maintain order, then reasoning had it that the Communist superpower would. Intelligence sources in the North Atlantic Treaty Organization (NATO) were becoming increasingly concerned about Communist intentions in several areas.

2. Situation Update

a. After emergency consultation with key members of Congress and the National Security Council (NSC) on the situation in the one oil producing region, the President ordered immediate deployment of ground forces to the area.

b. It was noted that the rapid movement of the force required augmenting the Military Airlift Command (MAC) with Reserve Component units and air crews. There was also concern that the task force was deploying with Active Component combat support and combat service support units that might be required for other contingencies, especially in light of reported increased activities in Europe. It was argued that Reserve Component units should be activated to replace them.

c. The initial elements of the task force, including the advance parties of units designated for early deployment, were enroute to the region within hours after the decision was announced. The remaining units followed by airlift and sealift in accordance with the OPLAN approved by the JCS. Personnel and selected items of equipment were moved rapidly by airlift. CNO notified the Chain of Command to release the MPUAS personnel designated to accompany the deploying units of the task force.

d. US forces arrived in the country without incident, although the radicals reacted predictably to the US presence by increased acts of terrorism. Within a week, a second moderate nation requested US forces. The Communists continued to threaten intervention but took no overt action. They did, however, announce a further expansion of their ongoing military exercise.

e. The initial departure of MPUAS personnel from activities and the potential for further MPUAS losses will result in a reduction of capability to continue the level of health services currently being provided in the command. The Commanding Officer has responded by calling together the Directors of Clinical, Nursing, and Administrative Services and tasked them to determine the residual capability to provide health services after the MPUAS personnel have departed. Concurrently, the commander began to assess residual dental capabilities. You were also aware that upon declaration of mobilization your inpatient services would be limited to the care and treatment of active duty personnel. In view of this eventuality, you asked the Chief of Patient Affairs, in coordination with the Directors of Clinical and Nursing Services to develop a patient disposition plan describing the criteria, procedures, and coordination necessary to implement the discharge or transfer of all non active duty inpatients.

f. How many inpatients can be discharged to home care?

g. How many inpatients by clinical service will continue to require hospitalization?

h. How many inpatients will require nursing home or rehabilitation type care?

i. What is the capability by clinical service of local health care resources to accommodate the treatment needs of patients requiring further hospitalization and/or outpatient care?

j. Develop a patient-disposition plan describing the criteria, procedures, transportation, and coordination necessary to implement the discharge or transfer of all non active duty inpatients.

k. What inpatient and outpatient services cannot be supported (including whole blood collection)?

1. What officer and enlisted training missions must be discontinued?

m. To report actual capabilities once MPUAS personnel have departed, prepare, for purposes of a drill, provide current inpatient and outpatient medical treatment capabilities by area of concentration. Provide backfill requirements (NOBC/NEC) to restore command to 75% pre-mobilization capability using the format below. Read in four columns: specialty (clinical/administrative), NOBC, NEC, shortage or overage:

(1) indicate shortage/overage from 75 percent premobilization capability. Ensure inclusion of persons assigned to branch medical clinics under your command and all persons currently in alert status.

(2) Please provide number and types of persons on contract, partnership, or resource sharing agreements.

SITUATION 4: 200K CALL-UP AND INITIATION OF PARTIAL MOBILIZATION

1. Scenario

a. The political situation in several Communist countries continued to deteriorate. It was announced that a major exercise would take place within the next few days. Intelligence sources reported that the semiannual rotation of communist troops had been delayed indefinitely with the forces remaining in an exercise status. Travelers reported an unusually high volume of military traffic on the roads, particularly ammunition trucks.

b. Intelligence sources confirmed that the Communists had activated and augmented key military command and control facilities and networks. Western military analysts postulated that they had decided it was to their advantage to move now, in Europe, while the United States was heavily committed elsewhere. All indications pointed to Communist preparations for war. It was clear that they were poised to attack, with an invasion of the strife-torn Communist country appearing imminent. The Supreme Allied Commander Europe (SACEUR) recommended immediate reinforcement of Europe in accordance with established plans.

c. Meanwhile, the situation in other areas had not improved, especially in the oil producing region where US military assistance had been requested. Tensions remained extremely high even as the US task force arrived. Intelligence sources reported additional troop movements in the area; however, the motives behind the moves were unknown.

2. Situation Update - Part A: 200 Call Up

a. Responding to the earlier concerns for the need to replace the CS and CSS units deployed with the task force from the Reserve Components, the President authorized the call-up of 200,000 personnel from the Selected Reserve for a period of 90 days.

b. The President's announcement of the 200K call-up provided units and individuals of the Selected Reserves to predesignated medical/dental activities. The arrival of these Reserve Component (RC) units will result in an increase in capability to provide health service support to the mobilizing and deploying forces.

c. Situation Questions:

(1) As an activity that receives RC augmentation during the 200K call-up, describe your plans to in-process, billet, train, and integrate the individuals/unit(s) into your organization.

(2) What is your command's policy on credentialing of Selected Reserves?

(3) Describe the procedures that occur when SELRES units mobilize at your activity.

(4) Assess your SELRES's capability and describe by clinical and support service their overall ability to enhance the accomplishment of your mission to reestablish the CONUS base.

(5) What are the procedures you must take to assist SELRES in adjusting their mobilization billets to support your activity's requirements?

(6) Describe the assessment process that your activity uses for determining if IMAs are required during the 200K call-up. What agency and by what means are IMAs activated?

(7) Who recruits individuals for authorized IMA positions?

(8) What problems exist at semi-active activities or other activities in your health service area where personnel, supplies, equipment, and facilities are minimal or nonexistent? Discuss your solutions to these problems.

(9) Discuss your capability at this point to continue to provide health care support to dependents and retirees since only the 200K call-up has been initiated.

3. Situation Update - Part B: Initiation of Partial Mobilization

a. Thirty days later the NSC met to review the effect, if any, of the 200K call-up. The latest developments in the two areas of greatest concern were examined to determine what steps should be taken next. In view of the evidence of increasing Communist activity in both areas, the Secretary of Defense recommended a declaration of a national emergency by the President or Congress followed by a partial mobilization. He pointed out that a Presidential declaration would provide authority to call up to one million reservists for a period of up to 24 months, whereas a congressional declaration could provide for full mobilization of the current force.

b. The NSC concluded that the partial mobilization authority derived from a Presidential declaration would be adequate and the most prudent course to follow.

c. The President agreed with the NSC recommendation and late that day addressed an emergency session of Congress. He announced that he was declaring a national emergency and directing the activation of Reserve Component units, individuals, and the recall of certain retired personnel for a total of one million personnel.

d. The partial mobilization decision generated a multitude of actions in the Department of Defense (DOD) and other Federal departments and agencies. Crisis action organizations were activated or expanded. The JCS, which earlier had formed a Crisis Action Team, activated the Operations Control Group. The Office of the Secretary of Defense (OSD) Crisis Management Organization (CMO) was activated, and the Military Services augmented their existing crisis management teams (CMTs) and similar organizations.

e. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) met with the Secretary for Veterans Administration (VA) to commence contingency planning. Each of the Services was requested to formally present their capabilities to support the force at the mobilizing stations. The National Disaster Medical System (NDMS) was not activated; however, the Federal coordinating centers, both VA and military, were directed to make their capability assessments.

f. The ASD(HA) and the Services' Surgeons General established the Health Affairs Advisory Board with membership from the Joint Staff and other Federal and civil agencies. The board supports and provides priority information to the Crisis Analysis Group and Crisis Coordination Group as part of the total Secretary of Defense CMO.

g. The Secretary of Defense directed the Services to curtail all unobligated construction contracts. The ASD (Production and Logistics) established a panel to review mobilization construction

requirements. Unobligated funds were withdrawn from the Services, and mobilization requirements were funded through reprogramming.

h. The OSD Comptroller issued requirements for revised budget estimates in anticipation of an emergency supplemental appropriations request to Congress.

i. The Chief, BUMED, has requested all commanders to furnish an assessment of their capability to provide health services to the mobilizing, deploying, and trainee populations at their commands through M+30 days. Upon receipt of this request, your Commanding Officer directed his key staff to brief him on your command's assessment of capability to provide health services in support of the installation's mobilization mission.

j. Situation Questions

(1) You have been directed to complete a review of the status of all personnel, including all active duty remaining after MPUAS personnel have departed, assigned civilian personnel, contract providers, all sources of Reserve Component augmentation and retirees. Discuss your mobilization MPA requirements and your available assets.

(2) In consideration of all available personnel indicated above, what is your capability to provide health services in support of your installation's mobilization mission? Use the Health Services Support Capability Worksheet and indicate the number of beds by major ASMRO contingency medical regulating categories, ORs, clinics, and DTRs that you are now capable of operating. Discuss your capability or the lack of it.

(3) Discuss the planning factors that you used to determine your projected mobilization patient workload.

(4) What plans have been developed, coordinated, and approved to provide health services not within your capability?

(5) Discuss the procedures you use to verify the skill level of your RC personnel.

(6) What impact does the level of skill readiness of the RC backfill personnel have on the MTF's capability to provide health care?

(7) How do you plan to provide the training required to bring RC personnel up to acceptable skill levels.

4. Situation Update - Part C: Capability Review

a. Situation Update - Commanding Officer Responsibilities. During mobilization, medical/dental commanding officers in their role as Director of Health Services, provide special staff advice and expertise to the activity commander. In addition to ensuring the currency of the medical annex to the Activity Mobilization Plan, the Director of Health Services assists the activity commander in validation of deploying medical units, and coordinates the use of early mobilizing late deploying medical units for support.

(1) How do you maintain visibility over installation medical personnel assets?

(2) Discuss your responsibilities to the activity commander concerning the validation of deploying MPUAS personnel.

(3) How will you task organize your staff to assist the installation commander in validating deploying MPUAS units. Have individuals been identified and trained to support the validation mission?

(4) Describe your plan for meeting the blood donor center requirements at your installation. How is your plan incorporated into the activity's mobilization plan? How do you propose to ensure that personnel who have volunteered to donate blood have blood drawn before receiving immunizations?

(5) Describe the plans and procedures that will provide for scheduling and transporting donors to the donor center in sufficient numbers to meet your daily requirements.

(6) Do you have enough supplies and equipment on hand to meet your daily whole blood requirement? If not, at what time period would you run out of supplies if you were not resupplied?

(7) What other potential sources are available to assist you in meeting your blood donor center requirement?

b. Situation Update - Preventive Medicine. The rapid expansion of the Armed Forces during mobilization and sustainment places an increased demand and emphasis on preventive medicine activities at the activity level. Attendant to the increase in the military population is the increase in the incidence of respiratory diseases, greater demands for living facilities, increased requirements for water and sewage systems, and solid waste disposal facilities. To accommodate these increased demands, ongoing preventive medicine programs such as communicable and infectious disease surveillance, environmental health surveillance, occupational health services, and community health nursing will have to be expanded. The importance of sound, executable preventive

medicine programs during mobilization and sustainment cannot be understated. Therefore, it is imperative that planning and resource identification take place on a continuous basis.

c. Situation Questions and Topics. As the Preventive Medicine Officer, identify and discuss your requirements and capabilities for mobilization and sustainment support in your activity. The following factors should be considered:

(1) Population to be supported - Base support, mobilizing and deploying, trainees, family members (active duty), civilian workers.

(2) Facilities - Hospital expansion, troop quarters, new construction, inactive facilities scheduled for activation, dining facilities.

(3) Sanitation - Field kitchens, solid waste disposal and sewage, water sources.

(4) Insect and rodent control.

(5) Industrial base expansion.

d. Given any shortfalls in your capabilities compared to your requirements, how do you plan to accomplish your mission?

e. What support would you require from the Naval Environmental Health Command during mobilization and sustainment?

f. What coordination or agreements have you made with state and local public health and community service agencies and other uniformed Services' preventive medicine activities to assist you in accomplishing your mobilization and sustainment mission?

g. Situation Update - Director of Dental Services Responsibilities. During mobilization commanders of Dental Services provide special staff advice and expertise to the activity commander. In addition, the dental commander assists the activity commander in validating deploying dental units. The dental commander is also responsible for ensuring that all deploying personnel undergo a dental examination and providing other dental care as required.

h. Situation Questions

(1) What is your capability to provide dental examinations and treatment to the mobilizing and sustaining force at your

installation? This assessment should take into consideration the time required per examination, and the availability of personnel, facilities, supplies, and equipment.

(2) Discuss how you plan to implement curtailment of dental services to other than active duty at your activity. Who has authority to curtail services?

(3) During mobilization the amount of time available for training is at a premium. Discuss how you plan to reduce lost training time due to personnel receiving required dental care.

(4) As a general rule, USNR enlisted dental personnel do not perform in their NEC during peacetime. How do you provide training required to bring Reserve Component personnel up to acceptable skill levels?

(5) What arrangements have you made for dental care for other activities in your Health Service Area and for Reserve Component personnel at their home station awaiting movement to their mobilization site?

SITUATION 5: PARTIAL MOBILIZATION - FACILITIES AND LOGISTICS

1. Scenario

a. Deployment of the task force and the initiation of partial mobilization had temporarily deterred aggression by those countries in the oil producing region unfriendly toward the United States and its allies. The Communists continued their condemnation of the United States for moving troops to the area but received little support from countries outside their own sphere of influence. With the potential for hostilities still extremely high, US forces remained deployed and conducted a combined exercise with military forces from friendly countries that simulated the defense of key oil production and distribution facilities against guerilla and conventional assaults.

b. The serious situation in Europe remained essentially unchanged. The return of dual-based units was approved, and they had begun to arrive and deploy to their forward locations.

2. Situation Update

a. The expansion of the active force and the deployment of units to an essentially bare base area resulted in immediate shortages of supplies, equipment, and transportation. The first order of business for the logistics community was to identify the items in short supply and allocate them to the various claimants.

Highest priority was given to the requirements of the deployed force. Of critical concern was the potential for greatly expanded requirements if hostilities erupt in other areas.

b. Even before the decision to implement partial mobilization, the Services and the Defense Logistics Agency (DLA) had begun review of the DOD Master Urgency List (MUL). This list specifies the critical production items that require special attention and includes items having the highest national priority, requiring approval by the President. Other materiel included on the list are those having the highest DOD priority due to their essentiality and criticality to combat forces, which requires approval by the Secretary of Defense. The materiel making up the remainder of the list is required to support expansion of the Armed Forces and to support war reserve requirements. In peacetime, the MUL generally reflects high-cost strategic systems or other programs with high visibility. During an emergency, the MUL requires modification to reflect the items of warfighting equipment needed to support the particular situation. After the review, the Services' and DLA's recommendations are passed to the Joint Materiel Priorities and Allocation Board, which adjudicates intra-DOD claims on materiel items in short supply. Once approved, they are passed to the JCS for approval of the MUL and sent to the Secretary of Defense. When all approvals, including that of the President, are received for applicable items, they are forwarded to the Federal Emergency Management Agency (FEMA) and finally to the Department of Commerce to make necessary adjustments in the Defense Priorities System. This system, established by the Defense Production Act of 1950, empowers the President or his agents, under the direction of FEMA, to establish priorities in performance of contracts or orders necessary to promote the national defense.

c. The President also delegates to the Secretary of Defense the authority to release National Defense Stockpile materiel. These stockpiles, which the General Services Administration currently maintains, contain about 100 types of raw materiel with a value in excess of \$11 billion. Defense contractors who cannot obtain the necessary raw materiel work with the Services and FEMA to obtain them from these stockpiles.

d. The expansion of the health care treatment base in CONUS to support the mobilizing and deploying forces and returning theater-generated patients is a major mission of Navy medical/dental activities. It is, however, one that is rarely, if ever, actually practiced. The ability to rapidly expand the number of available beds required to support a mobilization effort is hampered by a lack of well-maintained expansion facilities and enough equipment and personnel to operate them. Compounding this situation is the fact that the number of operating beds in CONUS has declined over the years as the practice of medicine shifted to providing more ambulatory care. Many hospitals have converted ward space to

clinics or other administrative uses more suited to the treatment of a peacetime Navy, its dependents, and other authorized beneficiaries. The ability to reclaim these facilities quickly is dependent on equipment availability, relocation plans for the clinics or administrative functions, and staffing.

e. The Navy Medical Department has a recognized requirement for 10,216 beds in CONUS. Expansion to meet the medical and dental requirements and other associated support falls to each activity commander.

f. Situation Questions and Topics

(1) What is the estimated number of beds required at your activity to support the mobilizing and deploying forces.

(2) In planning for hospital expansion, what is the maximum number of beds you can operate (assuming staff is available) in your present hospital facility, including all reclaimed areas that had been converted to other uses? How does this compare to your bed-expansion requirement from M-day through M+30? What criteria did you use to determine space requirements to support acute care beds?

(3) What alternatives other than new construction are available at your installation to meet your expansion requirements? What actions have you taken to ensure that alternate facilities will meet patient care needs.

g. Do you have enough equipment on hand to meet your expansion requirement through M+3 months? Indicate the number of equipped beds by category that you can put into service by M+60. Also include the number of ORs, health and branch medical clinics, and DTRs that you have sufficient equipment on hand to operate in a realistic manner. Do not consider staff or facilities at this time. What major equipment shortfalls exist to preclude you from meeting your established expansion requirement.

h. Are consumable/expendable medical supplies to be distributed under a similar priority system as the equipment? If not, how can you be assured of obtaining those supplies necessary to operate your expanded facility?

i. What nonmedical mobilization equipment requirements have you identified to your installation? What is the installation doing to ensure that the equipment will be available to meet your expansion requirements?

j. Separate mobilization expansion plans are to be prepared by medical/dental activities where a patient facility is to be operated upon mobilization. What type of logistical support is expected to

be provided to those off-site locations? What type of support does the installation provide? Is enough equipment on hand to meet the expansion requirement through M+30 days. If not, what major equipment shortfalls exist?

k. What kind of arrangements have you made to ensure that adequate medical maintenance support is provided to those dental clinics operating expanded hours or on double or triple shifts?

l. What logistical support do you provide to local Navy Reserve Processing Centers? What effect would the operation of these facilities at maximum output have on the support you provide?

m. During mobilization and the deployment of units at your installation, what are the types of units that deploy? What volume of supply demands could you expect from the deploying units? In what time periods would the highest workload occur? Who has responsibility for computing gross medical materiel requirements for these units?

n. What medical support functions have you identified that could be fulfilled by civilian contract during mobilization? What steps have you taken to ensure the viability of this program.

WORKSHEET

EQUIPMENT STATUS REPORTING

The intent of this worksheet is for each activity to identify your expansion capacity based on the availability of equipment at your installation. All available equipment should be considered.

Expansion Capacity in Acute Beds**

M+Day	M+30	M+60	M+90	Total
-------	------	------	------	-------

_____	_____	_____	_____	_____
-------	-------	-------	-------	-------

Operating Rooms/Delivery Suites	_____
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Branch Medical Clinics	_____
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Dental Clinics	
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WORKSHEET

SITUATION 6: PATIENT EVACUATION AND REGULATING

1. Scenario

a. After a period of calm the adversaries in the area of the deployed US task force renewed their threats against neutral countries and those friendly to the US. These threats culminated in the closing of a vital international shipping channel used by the many countries exporting oil and gas from the region. It was stated that any ships attempting to transit the area would be attacked and any attempt by the United States to reopen the shipping channel would be dealt with accordingly.

b. Offers by the U.N. to mediate the situation on behalf of the neutral nations met with failure. Two commercial ships that tried to pass through the channel were attacked and heavily damaged by aircraft operating from a nearby airfield.

c. After a week, the United States finally gave the countries responsible for closing the channel an ultimatum to reopen it immediately or suffer the consequences. The demand was promptly ignored, thus forcing U.S. action.

d. US, allied, and friendly forces initiated a combined operation to reopen the shipping channel with the intent to ensure it remained open permanently. US and allied naval vessels sailed into the channel with orders to clear it of all hostile ships or obstacles. At the same time a combined amphibious operation commenced to secure the airfield and all other military facilities located within the area of the shipping channel and close enough to pose a threat. US forces met heavy resistance from well-fortified positions located throughout civilian populated areas. This negated, to a large degree, the use of air and naval support to the US ground forces. US casualties were much higher than expected due to well entrenched defenders and the need to fight house-to-house to eliminate resistance.

e. While US attention was focused on the area of hostilities, tensions began to escalate in Europe. Two days after US forces began their operation against the forces blocking the shipping channels, Communist units entered their strife-torn puppet state. Other forces were deployed in defensive positions along the inner border to screen the invasion from NATO interference. The NATO response was immediate as its Ministers requested all members to begin full mobilization to forestall any Communist advance into Western Europe.

2. Situation Update

a. Upon receipt of the request for support in NATO and the Council's recommendation to commence mobilization, the President and

the Congress acted swiftly. The President requested and received a congressional declaration of national emergency. He directed full mobilization of the Armed Forces and immediate implementation of plans for the reinforcement of Europe.

b. The President declared full mobilization for M-day and it was also to be the effective date for the Selective Service System (SSS) to resume inductions. Prior to mobilization, only 18- and 19-year old men had been required to register with the SSS. On M-day, the Director of the Selective Service announced the schedule for the registration of men from 20 through 26 years of age and conducted a lottery to determine the sequence in which registrants would be called for processing.

c. Meanwhile, prompt evacuation of the remaining US noncombatants in Europe was ordered. Many had already returned to CONUS spontaneously. The Departments of State and Defense cooperated to evacuate all remaining nonessential US citizens from Europe. The majority of the evacuees were flown directly to CONUS on aircraft returning after delivering military personnel to Europe. Reception in the United States was handled by the Department of Health and Human Services, which received invaluable assistance from the American Red Cross, the Salvation Army, and various other volunteer organizations. Arrangements were made to move the individuals to their homes as quickly as possible, though temporary accommodations were provided when necessary.

d. The phasing of the call-up of Reserve Component units and the coordination of deployment operations to make best use of available airlift and sealift were areas of immediate emphasis. The JCS, the Services, and the unified and specified commands coordinated the movement of personnel, equipment, and supplies. This was done as nearly as possible in accordance with the previously approved OPLAN.

e. Numerous other actions were taken in compliance with the orders to mobilize and deploy. One of the first was augmentation of DOD. The Coast Guard, elements of the Federal Aviation Administration, and selected resources of the National Oceanic and Atmospheric Administration were transferred to DOD for the duration of the crisis.

f. US reinforcement of Europe required large numbers of aircraft and ships. The needs were filled by a combination of emergency measures. Stage III of the Civil Reserve Air Fleet (CRAF) was activated, providing significant numbers of passenger and cargo aircraft to augment MAC. Additionally, aircraft from the NATO Civil Air Fleet (CAF) were made available to the United States in accordance with existing agreements. Aircraft were also made available to DOD under the War Air Service Program (WASP). The combination of CRAF, WASP, and CAF provided enough aircraft to

maintain the air lines of communications for personnel and airlifted materials to support military operations.

g. The initial attacks in the hostile region generated a stream of casualties that began flowing into CONUS military hospitals within 7 days. Critical to the initial stages of the conflict is the emphasis placed on the early return to duty of those soldiers who could contribute to the battle. The decision to evacuate a patient who is not expected to return to duty rests with the attending physician and hospital commander utilizing the theater evacuation policy. The early identification of those patients who will not return to duty and whose clinical condition allows them to be evacuated are moved rapidly to the CONUS base. These patients began returning to CONUS in the backhaul capacity of the C-141 fleet.

h. The movement of patients to the proper destination hospital in the CONUS base is primarily coordinated by the Armed Services Medical Regulating Office (ASMRO) and MAC. The movement from a peacetime to a wartime approach will be phased into operation. The decision to implement the VA-DOD Contingency Hospital System and the National Disaster Medical System (NDMS) is the responsibility of the Secretary of Defense. The implementation will require the medical treatment facilities with CONUS to adjust their procedures and be prepared to accept an expanded active duty population with a diverse spectrum of patient conditions.

i. The following questions should be reviewed for the mission and role of your medical treatment facility. In reviewing your plans and the extent of coordination accomplished to date, identify the planning processes that are being accomplished well and those that need additional emphasis.

j. Situation Questions - Patient Regulating and Movement

(1) How are patients regulated from a theater of operations to the CONUS base?

(2) How is the hospital capability matched with the patients' needs?

(3) Who has responsibility for the movement for patients to CONUS?

(4) Who has responsibility for movement of patients within the CONUS base?

(5) Who is responsible for determining the destination hospital upon the arrival of the patients in CONUS? How is this decision coordinated?

(6) How are intra-CONUS patients regulated within your region once the ASMRO contingency procedures have been implemented?

k. Situation Questions - VA-DOD Contingency Hospital System

(1) Who initiates the VA-DOD Contingency Hospital System?

(2) How does the individual treatment facility coordinate with the VA?

(3) Who determines which patients go to a VA hospital?

(4) How are patients controlled who are moved to a VA facility?

1. Situation Questions - National Disaster Medical System (NDMS)

(1) Who is charged with responsibility for coordinating NDMS? Who activates the system?

(2) What are the criteria used to establish NDMS regions?

(3) Who determines which patients go to NDMS/civilian hospitals? How are patients regulated to NDMS hospitals?

(4) As a designated Federal Coordinating Center, if applicable, discuss the policies and procedures that you have established to provide for implementation of NDMS in your region.

(5) Discuss the plans and procedures for maintaining patient accountability and providing administrative support to Navy patients admitted to civilian hospitals participating in the NDMS. Who is responsible for Army and Air Force patients admitted to these same civilian facilities?

(6) Have memoranda of understanding been established with VA and civilian institutions for local support of all active facilities, semiactive facilities, and State owned mobilization stations in your health service area?

SITUATION 7 - MEDICAL SUPPORT OF LOW INTENSITY CONFLICT (LIC)

1. Introduction. Current concepts of future conflicts indicate that the US military will be involved with more low intensity conflicts than medium or high intensity conflicts. Medical support of LIC requires a rethinking in terms of how and when the Armed Services will provide the support.

2. Definition. Low Intensity Conflict - a politico-military confrontation between contending states or groups below conventional

war and above the routine, peaceful competition among states. It involves protracted struggles of competing principles and ideologies. Low Intensity Conflict ranges from subversion to the use of armed force. It is waged by a combination of means employing political, economic, informational, and military instruments. Low Intensity Conflict's are often localized, generally in the Third World, but contain regional and global security implications.

3. Scenario. In response to a Low Intensity Conflict in the Pacific involving a country with numerous US military personnel, bases, and dependents, the US armed forces have been requested by that country to help restore order and to provide protection of US interest located there. Your medical treatment facility has been tasked to provide a surgical team, similar in composition to an MMART Surgical Team, to assist in the medical support of the LIC. Your surgical team must be ready to deploy within 48 hours.

4. The following questions should be reviewed on how this tasking will impact upon your medical treatment facility.

(1) What documents are used as the primary source of guidance for LIC taskings? Which documents are available at your command?

(2) Adjustments to your mission must be approved at different levels in the chain of command. Who approves the curtailment of services on temporary bases for inpatient and outpatient care at your MTF.

(3) What liaison planning has your facility made with other Navy or armed forces medical treatment facilities in response to LIC taskings?

(4) Determine what your responsibilities are to ensure personnel assigned to provide medical support to the LIC are prepared for deployment. What responsibilities have you delegated to specific members of your staff? How are these responsibilities carried out?

(5) Describe your procedures for alerting and recalling the LIC support personnel.

(6) How many of your LIC personnel have received the training necessary to survive in a hostile environment?

(7) What coordination has been made with the command's transportation officer to ensure movement of LIC personnel to their designated point of debarkation.

(8) Determine how the loss of LIC personnel will impact on inpatient care?

(9) What inpatient and outpatient services cannot be supported?

(10) What officer and enlisted training missions must be discounted?

CHAPTER 20
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OPNAVINST 1000.16G	Manual of the Total Force Manpower; promulgation of
DODDIR 1235.10	Mobilization of the Standby Reserve
SECNAVINST 1300.13	Naval Personnel Augmentation of the Fleet Marine Force
NAVMEDCOMINST 1500.8	Command Training Program
OPNAVINST 1740.4	U.S. Navy Single Sponsor/Military Couple with Dependents(s) Dependent Care Policy
DODDIR 3020.36	Assignment of National Security Emergency Preparedness Responsibilities to DoD Components
DODDIR 3025.1	Use of Military Resources During Peacetime Civil Emergency Within the United States, Its Territories, and Possessions
OPNAVINST S3061.1	The Navy Capabilities and Mobilization Plan (NCMP)
OPNAVINST 3061.2	Total Force Manpower Mobilization Plan (TEMMP)
OPNAVINST 3440.16A	Department of Navy Civil Disaster Assistance Program
NAVMEDCOMINST C3500.1B	Uniform System of Alert Conditions (LERTCON)

OPNAVINST C3501.2H

Naval Warfare Mission Areas and
Required Operational
Capability/Projected Operational
Environment (ROC/POE) Statements

OPNAVINST 4080.11

Navy War Reserve Material
Management

NAVSUPINST C4080.29

Navy War Reserve Prepositioned War
Reserve Material (PWRM) Projects and
Elements; NAVSUP Material Support

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Programming of Medical/Dental
Equipment

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Medical and Dental Investment
Equipment Requirements for Navy

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Banks

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Transfusion Services of the American
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Services Whole Blood Processing
Laboratories

DODDIR 5154.6

Armed Service Medical Regulating
Office

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Virus (HIV) Infection in the Navy
and Marine Corps

OPNAVINST 5510.1H

Department of the Navy Information
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Regulation

NWP-6 REV C

Operational Medical and Dental
Support

DODDIR 6010.17

National Disaster Medical System
(NDMS)

BUMEDINST 6150.1

Health Care Treatment Records

NAVMEDCOMINST 6230.3

Immunizations and Chemoprophylaxis

BUMEDINST 6320.1E

Medical Regulating to and Within the
Continental United States

BUMEDINST 6321.3

Bed Capacity, Status and Occupancy

DODDIR 6430.2

DoD Medical Standardization Board

NAVMEDCOMINST 6440.2

Mobile Medical Augmentation
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Lists for U.S. Naval Vessels, Fleet
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Communications Security Material Systems Manual 4K

Disaster Medical Assistance Team Organization Guide

DoD Medical Staffing Guidelines

Manual of the Medical Department

National Disaster Medical System Coordinating Center Guide

National Disaster Medical System Disaster Exercise Guide

NAVSUP Manual, Volume II

APPENDICIES

PEACETIME - TRANSITION TO WAR



PHASE 1

- Low Intensity Conflict
- Active Duty
- CRAF
- DODD 3025.1
- AR 500-60
- AFR 365-1
- OPNAV 3440.16
- Selective Mob
 - 10 USC 3500
- CONPLAN 7300

PHASE 2

- 200K Call Up
- CRAF
- 10 USC 673B
- DODD 3025.1
- CONPLANS
 - 7040
 - 7300

PHASE 3

- Partial Mob
- Full Mob
- Total Mob
- CRAF
- 10 USC 673
 - 688, 6485
 - 671A, 672
- DODD 3025.10
- CONPLANS
 - 7000
 - 7040
 - 7045
 - 7300



MOBILIZE THE FORCE
EXPAND CONUS BASE
CARE FOR RETURNING CASUALTIES



PRINCIPAL NATIONAL MOBILIZATION AGENCIES

PRESIDENT

- Establishes national policy for mobilization planning and execution.
- Declares domestic or national emergencies and issues executive order to mobilize units and/or individuals of the Ready Reserve.

CONGRESS

- Authorizes full or total mobilization by public law or joint resolution.
- Enacts legislation to reinstate the Military Selective Service Act.
- Increases numbers of military personnel and duration of partial mobilization.

NATIONAL SECURITY COUNCIL

- Develops, coordinates, and ensures implementation of policy approved by the President.
- Oversees NSEP programs.

FEDERAL EMERGENCY MANAGEMENT AGENCY

- Establishes policies for MOB preparedness of Federal agencies.
- Prepares and maintains Federal Master Mobilization Plan.
- Guides Federal regional councils and States in emergency preparedness.
- Serves as advisor to NSC.

DEPARTMENT OF TRANSPORTATION

- Preallocates required civil transportation resources.
- Controls priorities and allocates resources for moving passengers and materials.
- Activates National Defense Reserve Fleet and requisitions US commercial ships.

DEPARTMENT OF ENERGY

- Assures supply of petroleum products, electricity, solid fuels, natural gas, and gaseous liquids.
- Accelerates nuclear weapons deliveries to DOD.

SELECTIVE SERVICE

- Expands Selective Service System.
- Issues induction orders to satisfy manpower requirements, when authorized by Congress.

DEPARTMENT OF STATE

- Administers overseas noncombatant emergency evacuation.
- Arranges landing facilities and overflight rights.
- Formulates and executes political strategy.

DEPARTMENT OF JUSTICE

- Controls aliens and their property in the U.S.
- Assumes jurisdiction of violations of Military Selective Service Act.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- Promotes and supports State and local planning for health services.
- Develops national plans to mobilize the health industry and set priorities.
- Develops survival information programs.
- Assists State and local governments in providing emergency human services.
- Assists noncombatants evacuated from overseas areas upon arrival at U.S. ports of entry.
- Directs professional and technical training in civilian defense health skills.

PRINCIPAL DOD MOBILIZATION AGENCIES

DEPARTMENT OF DEFENSE

- Provides for military response.
- Directs the development and execution of plans for national defense.
- Provides guidance and tasking for MOB planning.
- Reviews standby legislation.
- Advises NCA on need for mobilization.
- Issues mobilization directives and announces F-hour, when authorized.
- Initiates action for legislation to commence the draft.
- Activates CRAF Stage II, as required, and Stage III, when authorized by declaration of national emergency.
- Develops and operates damage assessment systems.

JOINT CHIEFS OF STAFF

- Provide the framework for MOB planning.
- Advise NCA of military force requirements.
- Implement emergency actions to increase DEFCON.
- Implement OPLANs as directed by the NCA.
- Provide deployment guidance.
- Monitor MOB and deployment process.
- Initiate, direct, and control deployment as directed by the NCA.

MILITARY DEPARTMENTS

- Support deployed CINCs.
- Assess force capabilities.
- Provide MOB guidance.
- Review MOB plans and procedures.
- Issue alert order for RC units.
- Monitor MOB.
- Monitor deployment.
- Direct required base expansion.

FORSCOM

- Validates force requirements to support OPLANs.
- Prepares Army forces for commitment in support of national policy.
- Prescribes procedures, requirements, and responsibilities for MOB and deployment planning and execution (FORMDEPS).
- Mobilizes, activates, trains, and supports RC units.
- Coordinates movement requirements with JDA and TOAs (MTMC, MAC, MSC).
- Deploys forces as directed by JDA and scheduled by TOAs.
- Coordinates deployment changes with theater commander, JDA, and TOAs.

UNIFIED AND SPECIFIED COMMANDS

The principles, doctrines, and functions governing the activities and performance of the Armed Forces of the United States are set forth in JCS Pub 2, Unified Action Armed Forces (UNAAF).

	UNIFIED COMMAND	SPECIFIED COMMAND	JOINT TASK FORCE
Establishing Authority	President through the Secretary of Defense with advice and assistance of JCS.	President through the Secretary of Defense with advice and assistance of JCS.	Secretary of Defense of commander of a unified command (incl sub-unified), specified command, or existing JTF.
Criteria	<p>Either or both</p> <ol style="list-style-type: none"> 1. To accomplish a broad continuing mission by forces of two or more Services requiring single strategic direction, or... 2. A combination of the following: <ol style="list-style-type: none"> a. A large-scale operation b. A large geographic area requiring single responsibility for coordination of unified operations therein. c. Necessity for common use of limited logistic means. 	<p>To accomplish a broad continuing mission</p> <ol style="list-style-type: none"> 1. To ensure freedom of action without necessity for close coordination of operations which cross normal operational boundaries or 2. To provide strategic direction in an area used primarily by a uni-Service force. 	<p>To accomplish a mission with a specific limited objective and duration by forces of two or more Services which</p> <ol style="list-style-type: none"> 1. Requires close integration of efforts or 2. Coordination within a subordinate area and 3. Does not require overall centralized direction of logistics. <p>(Note: The coordination of logistic needs essential to mission accomplishment is not precluded. UNAAF 30257)</p>
Scope	Area or functional	Functional or area	Limited tactical tasks
Forces	Significant assigned forces of two or more Services.	Usually forces from one Service but may include units of other Services.	Two or more Services.
Staff	Joint	Usually one Service, but may include representation from other Services.	Joint or augmented for Service balance.
Authority (UNAAF 30201)	Operational command	Operational command	Operational command
Logistics	Directive authority (UNAAF 30203)	Directive authority	Coordination or control as essential to accomplishment of mission.
NOTES	Establishing authorities or unified CINC (thru JCS) can establish a subordinate unified command using same criteria above.	Specified commander cannot establish a sub-unified command.	JTF dissolved when purpose achieved.

Unified and specified commands

MILITARY SUPPORT OF CIVIL DEFENSE (MSCD)

1. National Security Decision Directive 259, approved by the President on 4 February 1987, lays out national policy on civil defense. The Department of Defense and the Armed Forces are indirectly involved in the execution of this policy through Military Support of Civil Defense. Key elements of NSDD 259 are that the policy:

- Continues the "all hazards" approach to management of national security emergencies.
- Provides guidance on the responsibilities at all echelons of government.
 - The Federal Government will focus on guidance to the public, State, and local governments and provide financial assistance.
 - States have primary responsibility for developing civil defense programs.
 - Local government will develop civil defense programs within the guidance established by the State.
 - The Federal Emergency Management Agency manages the civil defense preparedness within the Government.

2. Military Support of Civil Defense is divided into two categories: "Controlled Response" and "Automatic Response." Controlled response is addressed by CINCFOR CONPLAN 7045, MSCD, while automatic is contained in Service directives and addresses military responsibilities in the event of a surprise attack upon the United States. Poststrike responsibilities of the military in support of civil defense are the same for both categories.

3. Controlled response and automatic response correlate closely. For both categories:

- The process to address civil requests for support is the same.
- By DOD directive, the Commanding General, Forces Command is the senior commander and command channels are from CINCFOR to regional defense commanders, to joint State area commanders.
- All military forces are potentially available.
- Declaration of a civil defense emergency is a prerequisite for both categories. NCA is the declaring authority in controlled response; for automatic response, the authority is the appropriate commander in the established command structure.
- Control will be relinquished to civil authority as soon as that authority is reestablished.

FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA)

GENERAL

FEMA is the focal point within the Federal Government for dealing with a wide spectrum of emergencies affecting the United States in peace and war. It has a central role in domestic and national security emergencies, ranging from natural and technological disasters through wartime nuclear attack. FEMA's statutory responsibilities with respect to these emergencies involve: mitigation (prevention, risk reduction, and effects limitation); preparedness (policy, planning, programs, training, and education); response (active coordination of on-scene activities during an emergency); and recovery (restoring affected areas to normalcy). FEMA deals with all emergencies in a comprehensive time frame: preemergency, transemergency, and postemergency.

SUPPORT TO STATE AND LOCAL GOVERNMENTS

FEMA supports State and local governments in the fulfillment of their emergency planning preparedness. Earthquakes, floods, hurricanes, tornados, nuclear power plant accidents, dam safety, radiological and hazardous materials incidents, and strategic nuclear attack are a few of the areas in which FEMA works to enhance State and local government emergency management capabilities.

ORGANIZATION

The Director of FEMA reports to the President and works closely in emergency management matters with the National Security Council, the Cabinet, and the White House staff.

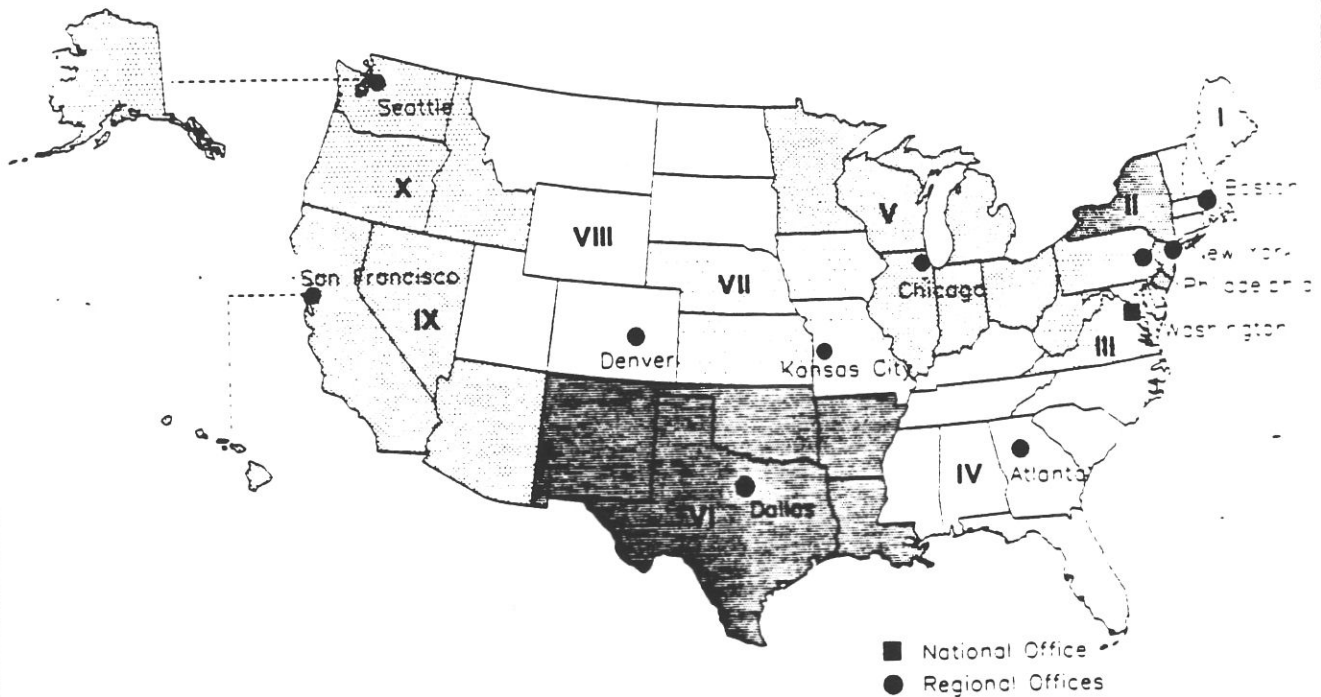
RESPONSIBILITIES

- Coordinate emergency activities through all levels of government - Federal, State, and local - and the private sector of the nation.
- Develop Federal program policy guidance and plans to ensure that government at all levels is able to respond to and recover from national emergencies.
- Conduct exercises on a regular basis to evaluate the quality and effectiveness of Federal plans.
- Assess national mobilization capabilities and the development of concepts, plans, and systems for management of resources in a wide range of national and civil emergencies.
- Identify shortages of natural, industrial, or economic resources that could constitute a threat to national security; develop plans to mitigate the effect of resource shortfalls; and establish programs to reduce the nation's vulnerability to resource shortages.
- Develop plans and programs to protect the population of the United States and key governmental and industrial components against the effects of enemy attack, to mitigate natural and technological hazards, and to minimize the negative consequences resulting from national security and serious domestic emergencies.

REGIONAL OFFICES

There are 10 FEMA regional offices. Each office is headed by a Regional Director who reports to the FEMA Director and is responsible for all FEMA programs in the region.

FEMA REGIONAL OFFICES



Region I (Boston)
442 J.W. McCormack, POCH
Boston, MA 02109
(617) 223-4741

Region II (New York)
26 Federal Plaza
New York, NY 10278
(212) 264-8980

Region III (Philadelphia)
Curtis Building, 7th Floor
6th & Walnut Streets
Philadelphia, PA 19106
(215) 597-9416

Region IV (Atlanta)
Gulf Oil Bldg, Suite 664
1375 Peachtree Street, NE
Atlanta, GA 30309
(404) 881-2400

Region V (Chicago)
300 South Wacker Drive
(24th Floor)
Chicago, IL 60606
(312) 353-1500

Region VI (Dallas)
Federal Regional Center, Rm 206
Denton, TX 76201
(817) 387-5811

Region VII (Kansas City)
Old Federal Office Bldg, Rm 300
Kansas City, MO 64108
(816) 374-5912

Region VIII (Denver)
Federal Regional Center, Bldg 710
Denver, CO 80225
(303) 234-6542

Region IX (San Francisco)
211 Main Street, Rm 220
San Francisco, CA 94105
(415) 556-8794

Region X (Seattle)
Federal Regional Center
Bothell, WA 98011
(206) 481-8800

Federal Emergency Management Agency (Continued)

APPENDIX G

BLOOD DONOR CENTER ALERT ACTIONS

The following actions are the minimum required to enhance BDC readiness to an alert status:

1. Review the following documents:
 - a. BUMED LSMP
 - b. Local BDC Contingency Activation Plan
 - c. NAVMED P-5123
 - d. Applicable BDC contingency activation guidance from supported CINC (overseas BDC).
2. Establish coordination between the BDC staff and the command public affairs office and prepare procedures for handling information inquiries from the media and other outside sources.
3. Notify designated points of contact within local donor providing commands of a potential need for increased blood donor support.
4. Determine blood product inventory required to meet in patient requirements.
5. Prepare to augment MPUAS and other BDCs, if tasked.
6. Coordinate the contingency BDC staffing plan with the internal services designated to provide support personnel.
7. Prepare and coordinate preliminary blood shipment procedures with the local shipping offices.
8. Inventory blood collection consumables and prepare requisitions for replenishment of any mission essential items.
9. Take any additional steps necessary to ensure an immediate quota execution capability.

APPENDIX H

BLOOD REPORT INSTRUCTIONS

1. A Blood Shipment Report (BLDSHIPREP) is the standardized report to be used in the worldwide Armed Services Blood Program. The Blood shipment Report Menu (BRM) will be used to prepare each report.

2. Blood shipments will normally be red blood cells. Blood group and type distribution from CONUS blood donor centers will be as follows: O POS (40%); A POS (35%); B POS (8%); O NEG (10%); A NEG (5%); B NEG (2%). Group AB blood will not be shipped.

3. Blood shipment messages should be classified if addressed to ships or if directed. Information copies should be sent to BUMED and the Area Blood System Director. Messages will be sent as priority due to very short blood expiration dates. Correct plain language addresses from a current directory must be used. Blood program facilities identification will be abbreviated by alpha-numeric characters followed by the facility type code from the BRM. Example: 609CONT-H (609th Contingency Hospital - Medical Treatment Facility).

BLOOD REPORT/BLOOD SHIPMENT REPORT MENU

MODIFIERS

FACILITIES:

C.	Armed Services Whole Blood Processing Laboratory	(ASWBPL)
D.	Blood Donor Center	(BDC)
E.	Blood Products Depot	(BPD)
F.	Blood Transshipment Center	(BTC)
G.	Blood Supply Unit	(BSU)
H.	Medical Treatment Facility	(MTF)
I.	Naval Vessel	(NV)

PRODUCTS:

J.	Red Blood Cells	(RBC)
K.	Whole Blood	(WB)
L.	Frozen Red Blood Cells	(FRBC)
M.	Fresh Frozen Plasma	(FFP)
N.	Frozen Platelets	(FP)

BLOOD GROUPS:

Q.	Random Group and Type O, A, B
R.	Random Group and Type O, A
S.	Random Group and Type O
T.	Random Group and Type A

	U. Random Group and Type B
	V. Random Group and Type AB
TIME FRAME:	W. Required within 12 hours
	X. Required within 24 hours
	Y. Required within 48 hours
MISCELLANEOUS	Z. Not applicable or see remarks

BLOOD SHIPMENT REPORT FORMAT

LINE ONE	Reporting unit name or code, type activity and location
LINE TWO	Total number of each blood product by group and type in shipment. In following order: O POS/A POS/B POS/AB POS/O NEG/A NEG/B NEG/ AB NEG//TOTAL//
LINE THREE	Airbill or transportation control number (TCN)
LINE FOUR	Airline and flight number or Military Airlift Command (MAC) mission number at destination
LINE FIVE	Estimated date, time, group of shipment arrival at destination
LINE SIX	Number of boxes in shipment
LINE SEVEN	Point of contact and twenty-four hour telephone number
LINE EIGHT	Narrative. Open text for comments

SAMPLE MESSAGE

FM: BLOOD DONOR CENTER

TO: ASWBPL

INFO: BUMED WASHINGTON DC//273//

DIR, AREA BLOOD SYSTEM

UNCLASSIFIED

SUBJECT: BLDSHIPRPT (AS OF DTG)

1. NH CHARLESTON
2. J/35/32/7/0/9/5/0/0//88
M/0/0/0/0/0/0/0/0/25//25
3. AB 11213
4. MAC 767
5. 211400Z MAR 86
6. 4
7. LT J. READY AV 383-6614/6615
8. BLOOD ICED 210600 MAR 86

APPENDIX I

DONOR CENTER ACTIVATION PLAN CHECKLIST

	<u>YES</u>	<u>NO</u>
1. Does blood annex/appendix exist to the command LSMP? If yes, then:	—	—
a. Has it been reviewed in the past 12 months?	—	—
b. Does it have a workable activation plan for full expansion of donor operations within 72 hours of notification?	—	—
c. Does the Laboratory or Blood Bank Officer have authorization to initiate requirements of plan upon notification?	—	—
d. Does the plan include requirements for communication concerning blood shipments?	—	—
e. Does the plan include primary and alternate transportation mechanisms?	—	—
2. Does the Activation Plan include the following areas:		
a. Donor Procurement:		
(1) Have military units been identified to donate blood?	—	—
(2) Have quotas been assigned to the units by specified time frame during mobilization?	—	—
(3) Do the military units have this requirement in their MOBPLANS?	—	—
(4) Will units provide the donors all at once or over a period of time?	—	—
(5) Have Reserve and National Guard units arriving as replacements for deploying units been identified and notified about blood donations?	—	—
(6) Is there a command information packet in place to recruit blood donors? Installation radio and TV? Bulletins? Installation commander meetings and messages, etc?	—	—

b. Blood Bank Operations.

(1) Is there identified space for expanded blood collections? — —

(2) Have personnel been identified and trained to support large scale blood collections? — —

(3) Will the personnel be available? — —

(4) Are blood bank equipment and supplies adequate to support requirements for large scale blood collections? — —

(5) Do plans exist to request dated blood bank items to support mobilization plan? — —

c. Blood Product Transportation.

(1) Do plans exist to transport blood products to a designated ASWBPL during mobilization and war? — —

(2) Are alternative transportation modes identified if CONUS is attacked? — —

3. Do command plans call for an immediate discontinuance of all civilian (Red Cross and other) blood drives on military bases, unless blood collected is for military shipment? — —

4. Is the expected population of military and civilian workers adequate to maintain the assigned quota for:

1 - 30 days — —

30 - 60 days — —

60 + days — —

5. Have you reviewed the Blood Donor Element Prepositioned War Reserve Materiel Stock (PWRMS) at your command within six months? — —

6. Does PWRMS inventory meet required levels? — —

7. Comments: _____

8. Checklist completed by/date : _____

APPENDIX J

DONOR CENTER READINESS CHECKLIST

1. Have you reviewed the blood annex/appendix to the Logistics Support Mobilization Plan (LSMP) within the past six months? YES NO
2. Have you reviewed the base LSMP concerning partial and full mobilization estimates of personnel aboard your base and nearby bases? YES NO

Please complete the following:

3. Present potential donor population (estimate):

Active Duty : _____
Civil Service: _____
Dependents : _____

4. Post Mobilization (M+1 DAY) donor population (estimate):

Active Duty : _____
Civil Service: _____
Dependents : _____

5. With present staffing, physical facilities, supplies and equipment, is your donor service able to ship the projected number of blood units as listed in the LSMP on a daily basis? YES NO

Comments:

Formal notification of BUMED-273? YES NO

6. How long following collection would it take to ship fully processed blood?

Same Day	Within 24 hours	Within 48 hours	Within 72 hours	Over 72 hours
----------	--------------------	--------------------	--------------------	------------------

Comments:

7. How long following collection would it take to ship blood, if processing (all laboratory testing) were done by the receiving unit or another facility?

	Within	Within	Within	over
Same Day	24 hours	48 hours	72 hours	72 hours

Comments: _____

8. To expand capability for shipments, is it feasible for arrangements to be made for assistance with donor collection with:

	YES	NO
a. Another military medical unit?	_____	_____
b. A local civilian blood center?	_____	_____
c. Nursing service at the local command?	_____	_____
d. Other (specify)? _____		

9. Could arrangements be made for assistance with blood processing/testing to expand capabilities for shipment with:

	YES	NO
Another military or DOD medical unit?	_____	_____
A local civilian blood bank?	_____	_____
A civilian private laboratory or hospital lab?	_____	_____

Comments: _____

10. What is the estimated maximum number of units of blood which could be shipped from your donor population following activation using available local assistance within:

	Processed	Unprocessed
72 hours	_____	_____
1 week	_____	_____
weekly, beyond first week	_____	_____

Comments: _____

11. What is the estimated maximum number of units of blood which could be shipped from your donor population if additional personnel, supplies and equipment were provided:

	Processed	Unprocessed
72 hours	_____	_____
1 week	_____	_____
weekly, beyond first week	_____	_____

Personnel needed: _____

Supplies/equipment needed: _____

12. Does your donor population include persons who may be considered part of a donor population by another DOD/ civilian blood collection center?

YES NO

If yes, have you coordinated with the other Blood Bank personnel to delineate separate donor populations following activation?

YES NO

Comments: _____

13. If activation were to occur today, and donor collections were to begin at your projected number, how many days of in-house, and PWRMS do you have available?

	Less than 7 Days	7-15 Days	16-30 Days	30+ Days
Donor Cards	_____	_____	_____	_____
HIV Testing Release Form	_____	_____	_____	_____
Copper Sulfate	_____	_____	_____	_____
Thermometer probes	_____	_____	_____	_____
Blood bags	_____	_____	_____	_____
Normal Saline	_____	_____	_____	_____

Antisera	_____	_____	_____	_____
HBs Ag Testing Kit	_____	_____	_____	_____
Anti-HBc Testing Kit	_____	_____	_____	_____
Anti-HCV Testing Kit	_____	_____	_____	_____
HIV Testing Kit	_____	_____	_____	_____
HTLV 1 Testing Kit	_____	_____	_____	_____
Shipping boxes	_____	_____	_____	_____
Ice capability	_____	_____	_____	_____
Shipping forms	_____	_____	_____	_____

14. Are realistic methods for obtaining additional blood bank supplies established if needed for activation requirements? YES NO

Comments: _____

15. Does the Blood Bank Officer and/or the Leading Petty Officer possess valid SECRET clearance? YES NO

Comments: _____

16. Do you have the equipment to draw donors? YES NO

a. At pre-established fixed sites away from NAVHOSP? _____

b. Using mobile collection equipment? _____

Comments: _____

17. How many trained and experienced personnel do you have following mobilization?

8501	8506	0000	Other Military	Civilian
------	------	------	-------------------	----------

a. Available to
draw donors. _____

b. Available to
process blood. _____

Comments: _____

18. Do any of the above civilians have reserve military affiliations?	YES	NO
--	-----	----

19. Have you ever collected in one day the number of units equal to your activation number?	YES	NO
--	-----	----

20. What is the largest number of units collected in one day during the past year?	_____
---	-------

21. How long after collection were those units completely processed and available for transfusion?	_____
--	-------

Comments: _____

22. Checklist completed by: _____
Date completed: _____

APPENDIX K

CONUS BDC RED BLOOD CELL CONTINGENCY QUOTAS

Service NAVY MAJCOM/MACOM BDC SEE BELOW

TIMEFRAME PLAN A PLAN B PLAN C

C-(C+10)

(C+11)-(C+20)

(C+21)-(C+30)

(C+31)-(C+40)

(C+41)-(C+50)

(C+51)-(C+60)

(C+61)-(C+70)

(C+71)-(C+80)

(C+81)-(C+90)

TOTALS

Assigned to the following

BDC'S: Designated ASWBPL

Note: Quotas are assigned to each BDC, and not to be divided between the three assigned.

